Harvey Agnew, M.D., Editor

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Obiter Dicta

Should Trustee Appointments be Limited?

HOW long should a hospital trustee remain on the board? Should he be retained as long as he is able and willing to work for the hospital or should there be some limitation to the tenure of his services?

It is not an easy matter to decide and it is questionable if any simple formula would be justifiable in all instances. In his book, "The Hospital Governing Board", Mr. Dewey Lutes objects to limited appointments as "this practice defeats long range programs and weakens the hospital by rapid turn-over in board membership. The members are lost at a time when they should, through acquired knowledge and understanding, be of greater value." We can think of scores of trustees who have served their hospitals faithfully and effectively for twenty to forty years and more and to whom their hospital interest is the very breath of life. Many have given generously of their means as well as of their thought and time—Mr. Lutes says: "Able and valuable members should continue in office as long as there is physical fitness and willingness to serve."

But that is only part of the story. We know also of trustees who are about as useful to their hospitals as a barnacle on a pile. They attend irregularly, or not at all. They contribute little to the discussions and are inactive or futile on committees. Worse, they may be quite active and lacking in judgment. However, at the annual meeting some kindly soul often re-nominates the entire board. Nobody would dare propose that the dead wood be replaced for fear of hurting someone's feelings; it is surprising how a little well-intentioned house-cleaning can split a town in two. Yet we know of a number of instances where a board has been completely rejuvenated by a transfusion of a little new blood and waning public confidence not only restored but greatly augmented.

The situation varies, of course, with the different types of hospitals. In the case of voluntary hospitals long tenure of office has been generally accepted. That every member of the board pull his weight is not insisted upon for a handful, unfortunately, must do most of the work anyway. In a municipal hospital, however, the public and press take a much more personal and critical interest in hospital affairs. There is a tendency, too, for some members to represent community groups rather than the patients and for those who are politically minded to use the hospital appointment to their own advantage.

The problem is to retain the valuable board member and to drop others without causing hard feelings. The only non-contentious way would seem to be to have a limitation to the period of office. A trustee would go off automatically, just like executive members in many organizations and the arrangement would be quite impersonal. Although no arrangement known to us would seem to be entirely free of some possible criticism, a plan that seems to offer the best solution is one that provides an initial appointment for a reasonable period, say, five years. That would be the accepted term of office. However, a valuable trustee could be reappointed for another five years. He then could be reappointed for a further term only after going off the board for one year. The advantage of this arrangement is that the man whose enthusiasm and willingness to work are short-lived can be replaced in five years but the good man can stay on for ten years. By that time many trustees, even hard workers, may have made their contribution and will be willing to let others and perhaps younger hands take over; some are well up in years when appointed. If, however, the trustee is particularly valuable and deeply interested, his connection will not be lost by the year off the board and he could then be re-elected for another five years, or, if desired, ten. Retirement of members should, of course, be staggered, so that a majority of the board will always have had varying periods of experience. In the case of "one-man" boards, where the chairman's interest and ability may result in most of the planning and action being centered in him, one advantage of the year of retirement is that an opportunity is thus afforded for other members of the board to develop executive responsibility.

The Campaign in Sydney

IT has been a pleasure to note the success of the campaign at Sydney, N.S., for the new 150-bed St. Rita Hospital. With a minimum objective of $300,000, the sum subscribed had reached $375,000 at the end of August and there were still some potential sources to be heard from. A noteworthy feature was that the entire campaign from start to finish was organized and conducted by voluntary workers—all local men and women who gave unselfishly of their time and thought. As a general rule we feel that professionally directed campaigns have a degree of organization, and knowledge of appeal methods and timing, which more than compensate for the cost, but the wonderful results at Sydney show what can be accomplished with local voluntary organization alone when the public are right behind the hospital.

We appreciate the action of Sister M. Augustine, the Administrator, in sending to our library a folder containing samples of their campaign literature, press publicity, weekly collection envelopes, et cetera. We wish other hospitals would do likewise, for material of this nature is in great demand by committees planning new hospitals or additions to existing ones. The more helpful literature of this nature is sent to us, the better can we make our package libraries which are borrowed by hospital committees.

The Refugee Physician Problem

THE medical profession is frequently accused of trying by every subterfuge to keep foreign physicians out of Canada. That the profession has only endeavoured to exercise reasonable safeguards on behalf of the public does not seem to be recognized. To make this clear, the College of Physicians and Surgeons of Ontario has published the report of its Committee on Education and Registration, listing the requirements and points taken into consideration before refugee physicians can be licensed to practise in that province.

(1) An applicant is required to become a British citizen before an Enabling Certificate is issued. In special cases the Council is authorized to waive this requirement.

(2) In many cases pre-medical and medical education is grossly inadequate by our Canadian standards. Although the standing of the various American schools is well known, no such study has been made of European schools. It *is* known that the standard of scholarship in the German medical schools fell to low levels after 1933 and a similar state of affairs has probably developed in other places on the continent. The standards must have been even lower in many of the occupied and war-torn countries during the recent war, resulting in very spotty medical education.

(3) It is considered essential that the applicant have a good command of the English language and/or the French language.

(4) To permit applicants to learn something about Canadian medicine, to become more closely acquainted with our ethical standards and mode of life, a minimum of one year's internship in a Canadian hospital is required. This replaces the former requirement of spending a year in a medical school here.

(5) Except possibly for an applicant who is an American citizen, all applicants must make a personal appearance before the Education and Registration Committee.

All applicants are considered separately. Each case is studied from the viewpoint of pre-medical and medical education, post-graduate training and intern experience, service in the Allied Forces during World War II, knowledge of the English language, length of internship in a Canadian hospital (and quality of his work), his desire concerning the nature and place of his future work, his method of coming to Canada, his present citizenship and steps already taken towards becoming a Canadian citizen. In a number of cases, the record has been sufficiently favourable that it has been recommended to the College that citizenship requirements be waived and Enabling Certificates be granted.

These considerations would seem to us to be fair.

The whole refugee physician problem, states the Report, is a tremendous one. There are probably some 3,000 displaced physicians who are anxious to emigrate to other countries, most of them being in the western zone of Germany. It has been indicated that there is a far greater need for physicians in many other countries than in Canada and, as a general rule, those who come to Canada wish to practise in the large centres rather than in our rural areas. Of the 46 alien physicians who have been licensed in Ontario since 1941, practically all are in Toronto or one of the larger Ontario cities.

An Enviable Record

THE current issue of the *Bulletin* of the Presbyterian Hospital in Chicago, in noting the election of one of its consulting physicians, Dr. Ernest E. Irons, to the presidency of the American Medical Association, recalls that Doctor Irons is the seventh member of the hospital staff to hold this high office. Five of the seven were elected president while serving on the staff and two were former members at the time of their election. The editor proudly claims this as a record—and a fine one it is, too.

This hospital might also claim to have been represented on the Board of Trustees of the American Hospital Association longer than any other hospital. Its former superintendent, Mr. Asa S. Bacon, was a member of the A.H.A. Board of Trustees for thirty-five years, serving from 1907 to 1942, mostly as treasurer but taking time out on one occasion to serve as president in 1923.

For honours in connection with the presidency of the American Hospital Association, we believe the Massachusetts General Hospital in Boston takes first place .

The Shortage of PATHOLOGISTS
and What to Do About It

H. G. Pritzker, M.D.,
Toronto.

THE present expansion of hospital facilities has presented far more problems than those involved merely with physical plant. The provision of adequate services is recognized as equally important as beds. For of what avail the beds if proper scientific diagnosis and guide to therapy is lacking? The present scarcity of trained hospital personnel is perhaps only a portent of the future distress which may exist when even more hospital plant is created.

In particular, as most hospital administrators are aware, there is a dearth of pathologists. This, even though today the scope and importance of the pathology laboratory is becoming ever greater. Very few young doctors are preparing themselves to become pathologists. Furthermore, all too many of our already limited number of well qualified younger pathologists have emigrated to the United States. Why? In an attempt to seek the fundamental reasons for this state of affairs the Ontario Association of Pathologists recently set up a study committee. This article is written to acquaint hospital administrators and trustees with many of the facts unearthed by this committee and with some of its suggestions.

Vital Service

In general the pathologist is the director of an important service in the hospital. As such, then, he should occupy a position similar to the heads of other important medical services. As his work is interwoven with the other departments, he should logically be a member of the Medical Advisory Board of the hospital.

In recent years, like other members of the hospital personnel, the pathologists have found themselves immersed in, and overworked with, routine. Adequate assistance, both technical and professional, along with reasonable vacation periods would do much to alleviate this strain. Time off to attend professional conventions and for post-graduate study should be encouraged. The importance of having the latest proven procedures available in a hospital laboratory does not require elucidation. Relief from day to day grinding routine allows one to think and leads to research. Research enhances the spirit of both hospital and investigator. It is the difference between an ordinary good hospital and one which leaves its mark for posterity.

The Salary Question

Today, the certified pathologist is a recognized specialist whose period of training has been on a par with other specialists. Yet, for some unaccountable reason, after many years of preparation the pathologist finds his salary to be less than the net income of a good general practitioner and certainly much less than other specialists. His salary is often less than that of other full-time specialists employed by the hospital, such as the radiologist.

No formula for deciding the compensation for a pathologist exists which can apply universally to all institutions. This much, however, is true. If more young doctors are to be encouraged in the study of pathology and if we are to keep those whom we have trained, then reasonable remuneration comparable to that of other specialists will have to be provided for pathologists. Whether this remuneration is based on straight salary, salary plus bonus, or salary based on percentage of gross income of the laboratory, et cetera, is of no moment unless the final figure is adequate, considering today's cost of living. Most pathologists feel, and rightly so, that they are entitled to perform laboratory work from outside the hospital, if possible, and receive remuneration for same. Most favour some scheme of compensation based on the revenue of the laboratory when this is feasible.

Increase Laboratory Income

Nearly all pathologists are well acquainted with the increasing financial burden which hospitals carry today, just as most hospital administrators are aware of and are sympathetic to the problems of the pathologists. To provide proper equipment for the laboratory and to pay the personnel of the laboratory fair salaries require a good income from the services rendered. A recent survey by the Ontario Association of Pathologists revealed a wide variation in the fees charged for given laboratory procedures by different hospitals. Most of the fees were low —much lower than the Ontario Medical Association and D.V.A. tariffs. These latter tariffs are reasonable and just. Hence the O.A.P. feel that these

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fees might be the accepted standard where possible. An adequate income from the work of the laboratory means the hospital can then afford proper facilities such as space, equipment, and sufficient trained personnel, as well as a salary for its pathologist which will stimulate many to pursue pathology as a specialty.

Hospital administrators have in recent years shown kindly interest in the ideas expressed above. More and more institutions, understanding laboratory problems, are providing their pathologists with better space, personnel, equipment, and remuneration. It is to be hoped that their far-sighted example will become the universal rule in all Canadian hospitals.

A Psychological Study

The Patient— His Friends and Relatives

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Director of Nursing,
Saint John General Hospital,
Saint John, N.B.

PSYCHOLOGISTS remind us that we cannot do otherwise than view the social scene from wherever we may happen to sit. We view it in the light of past experience, with emphasis on our own particular interest in the problem. The patient, his friends and relatives, create a situation to which patient, friends, relatives, nurse, doctor, and administrator, react quite differently, though sharing a common concern —the welfare of the patient. The patient being physically ill is to some extent mentally ill. His condition may be caused by fears and disrupting emotions, but if it is not, his anxiety over the outcome of his illness, his financial situation, or the problems of business or home where he is needed, may have a disturbing effect.

Illness reduces the status quo to a common denominator; the patient who is suffering from a cardiac condition, whether he is an indigent or a top executive, may step into an environment with which he is quite unfamiliar. Both suffer the indignity of being thoroughly questioned on admission. The indigent may be exposed to the curious gaze of numerous other patients in a large ward, the coming and going of staff, and the seeming impersonality of the whole hospital. The executive in his private room may be equally bewildered. He may be resentful of hospital routine, and of his inability to assume command of the situation. No longer does he issue the orders, but finds himself being persuaded to do as he is told by a mere youngster. Sensitive and insecure because of these factors, the patient may view the hospital personnel with suspicion and even resistance. Being ill, he is not expected to adjust himself completely to his environment; his environment must be adjusted to him and eventually a good rapport is established between the patient and nurses. But contributing also to his environment, are the patient's friends and relatives.

From a lecture given at the Maritime Institute for Hospital Administrators, Halifax, in June.

Patient Reactions

To the patient who is not seriously ill, but is the victim of a general malaise, including a severe headache, the presence of anyone in the room may be a cause of greater discomfort. "Just leave me alone", is his plea. Talking is an effort, even the slightest intrusion is irritating, and no doubt the patient's resentment against this intrusion further increases his irritability. Such a patient would gladly accede to a ban on all visitors, since it is unlikely that he will remain in hospital once his distressing symptoms have disappeared.

On the other extreme, there is the patient whose fractured leg compels him to idle away his time in hospital while otherwise he is feeling fit. For him visitors are a relief from the tedium of the day. He encourages them to come early and stay late. Noise does not bother him, so he is likely to be the centre of loud talking and laughter.

But the majority of patients are ill enough to need long periods of rest and quietness, highlighted by brief visits from friends and relatives whose presence assures them that their common human needs are being satisfied, that they are secure, they are loved, they are wanted, they belong, and so have a real personal worth. Said one young patient: "To come out of an anaesthetic after having my appendix removed and to see my family about me gave me such a wonderful feeling of knowing I was loved and wanted that I shall never forget it." "All I ask", said another, "is to see my wife sitting in the room, and I am perfectly content to go to sleep."

But there is the relative who will not sit quietly in the room, and in a spurious effort to cheer up the patient, chatters endlessly. He cannot resist the temptation to be the first to break the latest domestic news, however upsetting it may be. Or, in an effort to impress the patient with his interest in his well-being he may question him about details of his care, drawing to his attention signs of neglect, implanting in his mind seeds of dissatisfaction that may grow as the patient critically considers the care he receives.

There is the friend who feels the patient should know the pos-

Hospitals Welcome Royal Visitors

All members of the Royal Family take great interest in hospital work and visit various institutions from time to time.

—Courtesy of Hospital and Health Management

Above: Their Majesties with servicemen from Northfields Military Hospital, Birmingham.

Left: Their Royal Highnesses Princess Elizabeth and the Duke of Edinburgh chat with an 8-year old patient at Selly Oak Hospital, Birmingham.

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sible outcome of his illness, and regales him with a gloomy account of all those with the same affliction who have gone before. By such friends and relatives the patient is denied the sympathetic understanding and quiet reassurance he craves. Visiting hours may be over, but he is exhausted by counterfeit cheer, or worries—domestic or business.

A Help and a Hindrance

From her position in the hospital scene, the nurse views the friends and relatives as both a help and hindrance to the patient's progress. Because emphasis is being placed on the care of the patient as an individual, because the nurse is taught to accept the patient, not for example as a cholecystectomy case, but as a whole person complete with apprehensions, doubts and fears, she is keenly aware of the relationship of relatives and friends to the patient's recovery. They disrupt her routine, they interfere with treatments, they sometimes require much more reassurance than the patient. In case of serious illness they must receive consideration in the form of a comfortable chair or a cup of tea.

The nurse accepts all this as a contribution, good or bad, to her patient's environment. Ideally the nurse will regulate this environment by controlling the number of visitors, by tactfully suggesting to relatives the right approach, and by terminating visits that threaten to be too long. What she actually is doing no doubt, is trying to stem the persistent flow of visitors into the wards, receiving flowers and gifts, admitting new patients, attempting to carry on necessary treatments, and between times, answering numerous questions of visitors in a not too satisfactory way.

To doctors, relatives are often a nuisance. They interfere with the patient's rest, discuss subjects that cause anxiety, ask repeatedly for details of the patient's condition, and generally complicate matters.

The Administrator's Viewpoint

To the administrator the friends and relatives spell *public relations*. His contact with them is more or less limited to the time when a complaint is made, or more rarely, when he receives an expression of gratitude for the care of the patient. Because he is most anxious to maintain a good relationship with the general public, he must

About a Story That Wasn't Told

Emergency Departments Jammed as S.S. Noronic Flames at Dock

ON the night of September 16th, emergency departments in Toronto's downtown hospitals were scenes of furious but well-ordered activity as staff members coped with crowds of injured and overwrought passengers from the S.S. Noronic, burning at dock in the city harbour.

At St. Michael's Hospital and at the Toronto General, where most of the patients were taken, emergency departments were organized as casualty clearing stations. Dripping wet and dishevelled, burned, wounded, and suffering shock, the victims were given first aid and passed on to major or minor operating rooms, with surgeons and nurses working in teams. Immediate treatment included anti-tetanus serum, morphine, and penicillin. Large quantities of blood plasma were required and sufficient supplies were on hand. Close to 200 all told were treated, while 55 were admitted in these two hospitals.

During the days following this catastrophe, the local press and newscasters reiterated praise of the part played by city officials, by individuals, charitable organizations (particularly the St. John's Ambulance and the Red Cross), and by commercial companies, in rendering assistance to the victims. And well-earned praise it was. It is to be regretted, however, that with the exception of very early newscasts there was no mention of the contribution made by hospital staffs in allaying fear and suffering during those nightmare hours. It is true that reporters swarmed around the hospitals but their purpose was apparently to interview patients in the hope of gleaning lurid details for public consumption. Hospital authorities did confer with press representatives and, in one case, issued carefully prepared releases—but these did not appear in print.

Are those people who are trained to give succour in times of stress always to be taken for granted simply because it is in their line of duty? Hospital officials are proud of the manner in which their staffs rose to the emergency at 3 a.m. American citizens are still writing letters to express their gratitude for the prompt and efficient care tendered to them or their relatives. But the Canadian public, the people who are asked to support our hospitals, were given no opportunity to read that part of the story.—J.F.

formulate regulations that will protect the patient from an unreasonable invasion of visitors and, at the same time, retain their good will.

Many hospitals are experiencing a defiance of the rules and regulations that are made for the express benefit of the patient, whether it increases his opportunity to rest, or facilitates the carrying out of his treatment. I suggest that the reason for this is inherent in the reason for lawlessness in any place. People no longer accept authority without an explanation, even when the reason may seem obvious.

Religious and military hospitals, by their very nature, impose a certain restraint on behaviour, but as emphasis is being placed on public control of public property, demands for unrestricted access to that property are increasing. The public understand, in a vague sort of way, why regulations regarding visiting hours in a hospital are necessary but, too often, they consider their own circumstances unusual and requiring a special dispensation.

Are We Autocratic?

If I say that the unreasonable behaviour of the friends and relatives of the patient is a reaction to the autocratic behaviour of the hospital staff, will your immediate reaction be one of protest? You are sure perhaps that we have done nothing as administrators to merit the revolt of the public against our authority. Our sin may have been one of omission rather than commission. So familiar are we with the functioning of hospitals that we are inclined to forget that the whole institution is charged with mystery to outsiders—a mystery that had its inception in the use of professional terminology and Latin phrases. Or we may be among those who, consciously or unconsciously, enjoy the feeling of superiority given us by our own knowledge, and suggest by our behaviour that the uninitiated could not possibly understand the situation.

It is so much easier to make regulations than to develop a right attitude. Have we then been remiss in our relationship with the patient's friends and relatives because, if we examined our own behaviour, we would have to face the fact that we are afraid to relinquish what seems to be authority? Have we been remiss because we have not accepted the fact that the greatest power lies in ability to guide people with whom we come in contact, into good relationship with us and with one another?

Said Dr. Harry Emerson Fosdick: "An interesting revelation of human nature is presented in the chronological order in which the great sciences developed. Which science came first? Astronomy. Our first scientific knowledge concerned the things farthest away; and after that came geology, a little closer in, the story of the ancient background of our earth; and after that biology, somewhat closer in, the story of the world of life which has preceded us; after that sociology—in any scientific sense—still closer in, the story of the human setting into which our lives are born; and last of all, emerging only yesterday, postponed for centuries by our emotions and prejudices about ourselves, making us unable or unwilling honestly to face ourselves, came psychology."

We accepted the need for this scientific study of behaviour somewhat reluctantly, and first made

(Continued on page 72)

Reviewing the Nursing Situation

with particular reference to the Province of Alberta

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ALTHOUGH no national survey of the nursing needs of Canada has yet been made, it is estimated that the present nursing shortage in Canada stands at the appalling figure of 7,000. The Hon. Paul Martin, Minister of National Health and Welfare, has stated that his Department, through helping to build new and enlarge old hospitals, anticipated providing the Dominion with 40,000 additional hospital beds in the next five years. A rough guide as to the number of nurses required per bed is one nurse to every four beds. It will be readily seen, therefore, that if the Hon. Paul Martin is going to produce nursing service to go with these beds, he is going to have to devise some scheme of providing 17,000 additional nurses in the next five years. Someone should call this matter forcibly to his attention. Already in Alberta new construction has provided additional beds which are not in use due to lack of nurses to staff them.

On July 5th, 1948, the British Government's great scheme of national health went into effect. It was ushered in with an estimated shortage of 40,000 nurses.

In the United States a plan of national health insurance is under consideration by the Truman administration. The present estimated shortage of nurses in that country is 40,000.

No accurate determination of the shortage of nurses in Alberta has been made, to my knowledge, but one has only to speak to the administrators of the smaller hospitals to realize that the situation is most unsatisfactory.

Who is doing the nursing in Alberta today? If you consider nursing in its broadest sense, we have the following groups:

1. *Nurse Educators (B.Sc. in Nursing)*—This group is being produced at the University of Alberta. The educational entrance requirement is Grade 12. It is a five year course and this group should provide the instructors required to staff our schools of nursing.

2. *Clinical Nurses (Charge Nurses)*—Reg.N., or regular training school graduates. This group is being produced at eleven approved schools of nursing in the province in conjunction with hospitals. Entrance requirement, prior to March 1947, was high school diploma. Requirements, as amended by the Alberta legislature March, 1947, are not fewer than sixty-seven high school credits which shall include "B" standing in certain specified subjects. This is a three year course.

3. *Graduates in General and Psychiatric Nursing*—This is a four-year course available at the Provincial Mental Hospital at Ponoka. Two years of this period are spent in affiliated general hospitals in Edmonton or Calgary. Entrance requirements are the same as for the three-year course.

4. *Nursing Aides*—which are at present certified by the Department of Public Health after a year's training at the school in Calgary.

5. *Ward Aides*—In 1939, due to shortage of nurses, ward aides were introduced—an emergency measure meant to tide the hospitals over the difficult war period. They are virtually nurse helpers. They receive no training prior to being taken on the staff, but receive some training from the training school office and charge nurses during their course of duty. They are not licensed and have no official status.

6. *Orderlies*—They receive no instruction prior to being taken on staff but are trained by the older orderlies as they work. In my opinion, generally speaking, they are woefully undertrained. In England and in Eastern Canada there is the profession of male nurse. Some method of training male nurses in Alberta should be undertaken.

All of the eleven approved schools in the province are producing the maximum number of nurses that they are able to train.

Suggested Solution

Now, how is the problem to be overcome? How are more nurses to be produced in Alberta? As many of you know, a demonstration school was opened in Windsor, Ontario, in January, 1948. This school is financed jointly by the Province of Ontario and the Canadian Red Cross. It is designed to train nurses in twenty-six months. Part of the student's time is spent in the lecture theatres and part at the bedside, but all her time is devoted to receiving instruction and none to routine hospital duties. In other words, this system gets entirely away from the apprenticeship. The new school is designed to turn out clinical nurses, those having their Reg. N. on graduation. The school has been in effect too short a time to assess the quality of the graduate. But we have every reason to believe the results will be satisfactory, and the number of applicants is ever increasing. In my opinion, the answer in Alberta is a central school of nursing. The organization of such a school has been discussed now for over two years, and I think it is

(Concluded on page 98)

From an address presented at the 1949 Nurses Graduation, Royal Alexandra Hospital, Edmonton.

Dire Need for Education of the Public

Eardley Benedict,
Ottawa.

Some Observations Based on the Judicial Inquiry at the Ottawa Civic Hospital

EVIDENCE heard during the recent judicial investigation of the Ottawa Civic Hospital, in which the hospital and staff were exonerated,* revealed an astounding lack of even elementary knowledge on the part of the average person concerning the functions of a hospital. Since the inquiry was informal, persons bringing charges of negligence or inefficiency were allowed to tell their stories as fully as they wished, in whatever terms they wished. From these stories, told in good faith by complainants, several factors emerged:

1. General confusion as to what treatments were being given and the purpose of the treatments;
2. In the minds of many, gross ignorance as to exactly what constituted their illness;
3. Ordinary routine procedures misunderstoood and misinterpreted;
4. Confusion as to the line of responsibility between the attending physician and that of the hospital;
5. Any resentment shown was directed against the hospital, while, in general, there was confidence in the doctor;
6. A tendency in some witnesses to practise self-diagnosis.

As the hospital rebuttals began, with charts and case histories as evidence, there was definite proof that many people lose their heads in the face of illness. One woman stated under oath that she had contracted "cirrhosis of the liver" from a blood transfusion received in the hospital! Another stated that she had given birth to a child in her hospital bed with no attendant present. (The records revealed an abortion at four months with a nurse and an intern present, the patient being under sedatives). Other complaints were less dramatic and, where substantiated, could be traced to a shortage of nurses; but underlying most of the criticism was the feeling of the individual versus the institution, as though the patient were at the mercy of some monster.

**See "The Canadian Hospital," Sept. Pp. 27 and 36.*

Poor Liaison Between Medicine and the Public

How can such misunderstanding exist as to lead people to bring charges of the above type in good faith? How can ignorance of the simplest medical facts be so general that it is not confined to persons of limited education or intelligence? The fact that the editor of a responsible newspaper presented a series of such cases, without for a moment doubting the stories brought to him, argues that medicine and the public are looking at each other over a widening abyss of misconception. And this misunderstanding is not confined to Ottawa.

The medical field, with is vast mechanism of hospitals, laboratories, and clinics, is notorious for its poor public relations. The general public resents sickness, resents the time required for treatment, and resents paying for it. The man who will happily spend forty dollars on car repairs will wince at the same charge for medical or hospital care, a field in which, unhappily, there is no spare part department.

The fault seems to lie in poor liaison between the scientifically trained mind and the average man who consults a doctor concerning a vague pain "about here" which he has had "for some time". Their understanding of the whole thing is so different that for the doctor to explain fully every step in treatment seems as futile as attempting to explain symphony to a man who has never heard anything but a mouth organ. Not only would the explanation take infinite time but the consultant would probably have to spend much valuable time weeding out firmly embedded preconceived notions. Since time is precious, he may therefore, order treatment (in the hospital) without full explanation. The bewildered and sometimes frightened patient meets an efficient routine of blood tests, urinalysis, blood pressure, et cetera, in the sure conviction that each one spells doom, and his mind enlarges the importance of these checks. The nurse is trained not to discuss his case with him and so she exudes a smiling confidence whether his trouble is a broken ankle or cancer.

Suggestions

Since the trend is away from home-treatment and toward increased use of hospital facilities, it would seem essential that a definite effort be made by doctors and by hospital authorities to gain the confidence of the patient, to allay any vague fears as well as to treat his illness.

A first step in this direction might well be the preparation of leaflets, setting forth clearly and concisely, a step-by-step explanation of the various routines the patient will experience, and their purpose. In the commoner types of surgery, even some of the symptoms the patient will suffer might be listed, with the explanation that these are the ordinary result. This would help him to understand that the nursing personnel knows what to expect and what to watch for in his case. In maternity, especially in a first birth, a small pamphlet is invaluable, for very few enter that experience with any inkling of the various steps that confront them.

This type of literature would prepare the patient for many treatments, would reassure him about the necessity, the value, and perhaps even the cost of them. Though he may now complain about small unexpected items being tacked on his account, he may be surprised to learn that certain tests are required by provincial health

(Concluded on page 106)

Illustrations show three phases of an appendectomy as seen on the television receivers.

Permanent Television Installation at Guy's

A TELEVISION camera has been installed in the operating theatre of Guy's Hospital in London, England, with television receivers in three separate rooms. Students in the departmenal library, the exhibition room, or the lecture room, will have a close-up view of any operation being performed, stage by stage. While operations have been viewed in this way on many special occasions both on this continent and in England, Guy's is the first hospital to install permanent television equipment for teaching purposes.

Courtesy United Kingdom Information Service.

The installation has been designed with the co-operation of the Director of Surgery to meet the particular requirements of the medical profession and is the result of television research by Electrical and Musical Industries, Ltd. The C.P.S. Emitron camera assembly in the operating theatre is a striking departure from orthodox design. It is remotely controlled for lens selection and focussing, is almost completely enclosed (and thus concealed), and is built in, together with a microphone, as an integral part of the light over the operating table. The complete unit it carried on an "overhead railway". In designing the unit special precautions were necessary to eliminate any possibility of diathermy interference from the electro-medical equipment almost constantly in use at the hospital.

The television apparatus, with a monitor for control, is housed in a room off the operating theatre and is under the charge of a departmental technician.

On the screens of the 15-inch tube receivers can be seen the view immediately above the surgeon's hands, in contrast with the oblique angle and somewhat obscured view otherwise seen from a gallery. In three remotely selected stages, the area covered by the camera can be 20″ by 25″, life size, or a magnified close-up of an area about 5″ by 6″. The surgeon's skill can thus be watched as an operation proceeds and at the same time his observations are likewise audible to students.

Let Your Pharmacist Do It —

Your pharmacist should be in charge of sterilization and of the central supply, and do more manufacturing.

Perrin Statia, Phm.B.,
Chief Pharmacist,
Kitchener-Waterloo Hospital,
Kitchener, Ont.

IN the present day of specialization, it would seem advisable that sterilization be removed from the present haphazard control and supervision that obtains in many of our hospitals and be placed in the hands of a specialist trained in pharmacy, chemistry, and bacteriology.

One need not look far to find glaring examples of inadequate sterilization procedures. Underwood states: "It seems absurd, after fifty years of sterilization with the extensive use of steam, that the properties of steam is the important detail which has been overlooked altogether. The vague theories which have been used are unsound, full of incorrect assumptions and inconsistencies which are quickly revealed."

Steam Sterilization

Many are still using pressure s a criterion of sterilization; pressure, of course, has nothing whatever to do with the destruction of bacteria, being merely a means of attaining the desired temperature. There exists a great deal of confusion about "vacuum"; many nurse supervisors believe that vacuum plays some magic role in sterilization, whereas common sense tells us that vacuum is merely the removal of air and air steam from the sterilizer in order that the proper temperatures may be attained. Since the presence of air in a sterilizer theoretically reduces the ultimate possible temperature obtainable, it becomes evident that the commonly used but imperfect vacuum system falls far short of the requirements of dependable sterilization. It is impossible to create, with any known apparatus, a vacuum of sufficiently high degree to warrant its use at all, particularly when it is so easy to evacuate a sterilizer by simple gravity. Underwood places much emphasis on controlled sterilization, which would seem to be practicable only where sterilization is carried out in a modern central supply department and under proper supervision.

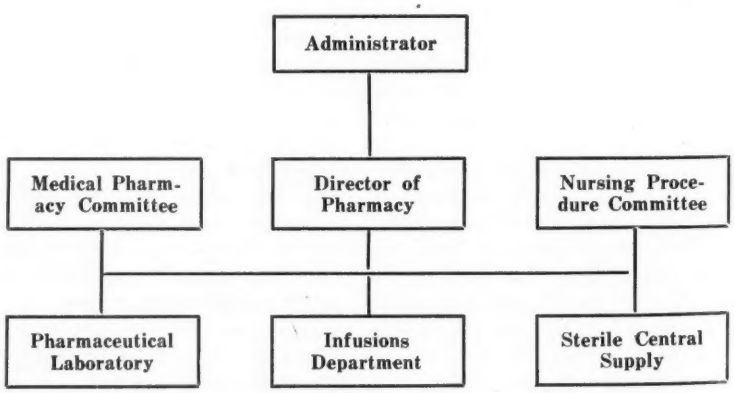
Training in Sterilization Techniques Necessary

With these facts in mind, it can be seen that a specialist is required to supervise this type of service. The hospital pharmacist is well trained in the various aspects of bacteriology and chemistry necessary for the proper understanding of sterilization. For instance, he knows the degree of heat to which various chemicals may be subjected without decomposition; when to use aseptic methods and a bacteriological filter candle; and when to use moist heat or dry heat. Consider the many hospitals where oils, greases, and powders, are put into autoclaves and the products used as sterile, or those which enclose materials in wrappers that are impervious or otherwise defy penetration necessary for sterilization. Sterilization theories and techniques are not understood by a nurse and are not intended to be. It is a highly specialized service, requiring intelligent and conscientious attention.

By placing sterilization procedures in a centralized department and under the control of a person properly qualified to operate it, we are rendering a safer and more efficient service to the hospital and to the patient; we are also relieving the nursing staff of duties for which they are not trained, giving them more time to spend on the improvement of patient care. In the text, *Hospital Care in the U.S.A.*, recently issued by the Commission on Hospital Care, it is stated: "Technically trained persons are needed in special departments . . . in the pharmacy the hospital must have competent people to conduct and direct these activities."

The only person qualified to direct a pharmacy department (manufacture of sterile and non-sterile products and sterilization in general) is a well trained pharmacist—certainly not a nurse who should be trying to improve her nursing technique rather

Figure 1



Plan of Organization

than attempting to operate a department which she is not capable of directing. At least 48 large American hospitals are now operating intravenous solutions departments and sterile central supply in conjunction with the pharmacy department and under the control of the chief pharmacist, and many others have made plans to do so.

Well Trained Pharmacist an Asset

The majority of Canadian hospitals are small (200 beds or fewer) and it is in these that the greatest improvement in pharmacy services is needed. Many have been making shift with a "drug room" in a hidden corner of the basement, their administration ignoring the legal, moral, and economic aspects involved. Small hospitals, utilizing the services of a nearby drugstore, would do well to remember that the drugstore is a private enterprise instituted for profit and cannot possibly render good economical service to the patient. Hospital sizes, packings, et cetera, are not available to the retail druggist and therefore items are more costly. The handling of drugs is a serious undertaking and should be the responsibility of a well trained and qualified pharmacist. The laxity that prevails in a great many hospitals in allowing nurses to perform such duties warrants public investigation and correction. A sick person in the home would not consider having his medicines prepared by other than a qualified pharmacist. Why, then, is he subjected to inferior service when he enters the hospital where all phases of medical services are expected to be on a much higher level than elsewhere?

Correlation of Departments

Our own institution has been operating, for well over a year, with the pharmaceutical laboratory, dispensing, intravenous and other injectable fluid manufacture, and the sterile central supply department under the control of the Director of Pharmacy. The personnel consists of three qualified pharmacists, three registered nurses, and three general duty help. The plan of organization as illustrated in Fig. 1 is such that other departments concerned may be consulted when and if necessary.

The pharmacy committee medical corresponds to what is more common-

Figure 2

Articles Issued by Central Supply

Sterile

abdominal dressings
aspirating tray
blood restart
catheterization tray
clip remover set
compress tray
cotton balls
dressing tray
douche set
duodenal tube
emergency tray
eye tray
gastric lavage
gastric gavage
gauze sponges
hypo tray, adult intramuscular
hypo tray, child intramuscular
interstitial tray
intravenous tray
insulin tray
individual hypo needles
local anaesthetic tray
pitchers
penicillin aerosol
perineal tray
plasma and blood sets
catheters
rubber gloves
suture remover set
scrub set
spinal puncture
stump dressing
surgical bowls
syringes 1-2-5-10-20 and 50 c.c.
syringes, urethral
syringes, bulb
throat irrigation
tidal drainage
tuberculin tray
v-pads

Unsterile

inhalators
electric heating pads
hot water bottles
invalid rings
v-pads
stupe kettles
ophthalmoscope
steadman pumps
rectal tubes
vangensteen
auriscope
bandages
levine tubes
percussion hammer
ice caps
throat collars
gauze sponges

Intravenous Solutions

distilled water	75 and 500 c.c.
sodium sulphate 3.2%	1000 c.c
5% dextrose in water	500, 1000, and 2000 c.c.
5% dextrose in saline	500, 1000, and 2000 c.c.
10% dextrose in water	1000 and 2000 c.c.
10% dextrose in saline	1000 and 2000 c.c.
saline 0.85%	75, 500, 1000, and 2000 c.c.
5% dextrose in ½ strength saline	500 and 1000 c.c.
vitamin solution of dextrose in saline	1000 c.c.
dextrose 3.3%, sodium chloride 0.21%	1000 c.c
dextrose 50%	50 c.c
dextrose 20%	50 c.c
dextrose 30%, sodium chloride 10%	50 c.c
ringers solution	1000 c.c
ringers solution ¼ strength	1000 c.c
ringers lactate solution	1000 c.c
sodium lactate solution	1000 c.c (1/6 molar)

congo red 1%
blood bottles A.C.D.
plasma bottles

Small Volume Injectables

hyoscine hydrobromide gr. 1/150 in 1 c.c.	30 c.c.
procaine hydrochloride ½, 1 and 2%	30 c.c.
codeine phosphate ½ gr. in ½ c.c	12.5 c.c.
morphine sulphate 1/6 gr. in ½ c.c	12.5 c.c.
morphine sulphate ⅛ gr. in ½ c.c	12.5 c.c.
morphine sulphate ¼ gr. in ½ c.c	12.5 c.c.

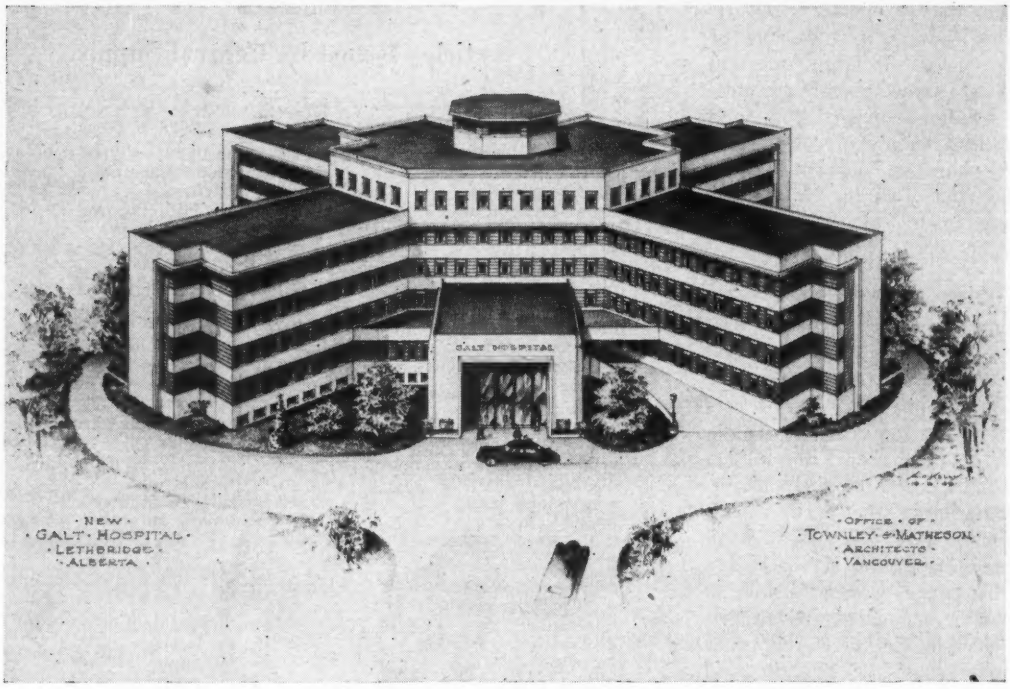
pyridoxine hcl 50 mg. in 1 c.c.
thiamin chloride 100 mg. in 1 c.c

Other Sterile Products

acriflavine emulsion	30 c.c.
petrolatum 100 gm.	100 gm.
	500 gm.
glycerin	500 c.c.
liquid paraffin	500 c.c.
sulphathiazole pdr.	5 gm.

Pouravac Solutions Sterile

boric acid 4%	500, 1000, 2000 c.c.
distilled water	500, 1000, 2000 c.c.
saline 0.85 %	500, 1000, 2000 c.c.



Proposed New Galt Hospital at Lethbridge, Alta.

Above is the architect's conception of the proposed new $1,500,000 Galt Hospital at Lethbridge, as planned by the hospital board.

Construction is being held up, pending the possible development of a municipal hospital district covering the city and some 200,000 acres of adjacent territory. The provincial government has stipulated that any hospital desiring provincial and federal grants for construction must municipalize their operational financing. A plebiscite on this issue will be held in October or early November and, if two-thirds of the ratepayers are in favour, the plan will be ratified and the construction grants allowed.

The proposed building will be of steel and concrete and be fire resistant throughout. It will be located just east of the present Galt Hospital where already a new power plant has been built and is in operation. This is of sufficient size to serve the new hospital.

The design is cross-shaped. For the present, three wings only would be erected, the fourth being added later. The three wings to be erected first would accommodate some 150 patients, all services and elevators being in the central section.

---

ly known as the formulary committee and is consulted on all problems dealing with medicinals and additions to, or deletions from, the hospital formulary. The chief of the medical staff is head of this committee. The nursing procedure committee decides upon tray set-ups. The policy is to provide trays as specified by this committee, which represents the nursing division, with the provision that all wrappers will be decided upon by the director of pharmacy in consultation with the bacteriologist and director of pathology. Wrappers are provided of the type and size required; the material used, however, constitutes a problem in sterilization and, as a technical point, is left to the decision of the director of pharmacy.

Sterile Central Supply

This sub-department prepares and issues sterile equipment and dressings to the various hospital departments and wards. Presently situated in a temporary location, it will be moved to the new hospital when that is completed and will be supplied with adequate electric dumb waiters, a pneumatic tube system, et cetera, to provide better service. It will be located directly below the pharmaceutical laboratory and connected to it. The present staff comprises five persons: two registered nurses, one of whom is the supervisor, and three general duty help. The remainder of the pharmacy staff gives assistance when needed, since all staff are trained in the operation of this department. Hours at present are from 8 a.m. to 6 p.m. daily, with the night supervisor obtaining emergency supplies if required after these hours. In the new building, the department will be responsible for operating and delivery room supplies as well and it is anticipated that 24-hour service will be necessary. Lack of space prevents handling these supplies at present. The supplies indicated in Fig. 2 are now issued from the department.

Equipment for Sterilization

This equipment consists of two built-in rectangular sterilizers, one 24 by 36 by 48 inches, the other 24 by 36 by 60 inches, with one circular sterilizer to be added in the new building. All are nickel clad to resist corrosion by solutions. A hot air

(Continued on page 68)

Ancillary Services —

A Benefit to the Community and a Factor in Hospital Staff Planning

C. U. Letourneau, M.D.,
Medical Superintendent,
Queen Mary Veterans Hospital,
Montreal, P.Q.

ANCILLARY services comprise all those hospital agencies which are concerned with the moral, social, and economic aspects of disease. They include chaplain services, medical social work, recreation, rehabilitation, education, vocational guidance, and welfare. They are peculiar to public institutions and are seldom used in private medical practice. Until the twentieth century, these services were looked upon as acts of charity performed by benevolent citizens of the community, desirable but not necessary to the treatment of the patients. Physicians regarded them with mixed feelings ranging from outright opposition to mere toleration. Observers noted, nevertheless, that hospitals with well organized ancillary services obtained better results in the treatment of patients than those with none and today ancillary services are considered essential to the treatment of public hospital patients.

Disease a Social Problem

From the medical standpoint, disease is a problem to be solved by recovery of the patient, by arrest of disease, or by death. The scope of the physician does not extend beyond the diagnosis and treatment of illness. The sequelae of disease and the attendant problems created by disability and maladjustment have never been considered as a medical responsibility. In private practice such social and economic disturbances are borne by the patient, his family, and his friends. Some communities now consider these problems as a public responsibility and in such communities the public hospitals treat disease as a social affliction. Under this regime diagnosis and therapy are most essential, but the patient is not considered cured until he has regained a useful status in society. The concept of disease as a social problem is still in the stages of development and experimentation. Some hospitals limit their services to the treatment of disease while others contribute more or less to the management of social problems attendant upon illness. The attitude of the hospital in this respect affects staff planning materially for the task is greatly simplified if no ancillary services are provided. Where ancillary services are organized and integrated into the hospital routine, however, a considerable addition to the staff establishment is involved, for these services are now rendered by career professionals.

Chaplain

The need for chaplain services requires no elaboration; chaplains have succeeded in many instances where medicine has failed. Hospital chaplains should possess a broad general understanding of disease, a pleasing personality, and an intelligent approach to the problems of the patient. As working members of the hospital staff, chaplains can render invaluable assistance to the treating physicians and spiritual comfort to the patients. Like other members of the hospital staff, they are specialists in their own field. Whether they are employed part time or full time depends on the size of the hospital and the religious persuasions of the patients.

Medical Social Services

Medical social services are also well established in hospital practice. The hospital physician does not visit the patient's home and family as he would do in private practice. He is relatively unaware of the patient's economic and social problems. The almoner studies the home environment and supplies the family contacts which are so essential to the understanding of the patient's illness. Almoners do not include those home visitors who investigate the patient's financial solvency with a view to protecting the hospital account. These are credit investigation agents although some writers refer to them erroneously as medical social workers. Briefly, then, medical social workers render aid to the physician, comfort and reassurance to the patient. The size of the medical social service department varies according to the type of community in which the hospital is located. Private hospitals have little need for this service but a large staff is required in a community where social problems abound. What must be determined before such a department is planned is the extent of the hospital's participation in community social problems. Lack of funds will often limit the hospital's interest in the social aspects of disease and, since the amount of money which can be spent on medical social work is almost without limit, the staff planner should be informed of the financial resources which are available for this type of work.

Recreation

Boredom is the dreary accompaniment of illness; it retards the progress of the patient and should be eliminated by means of bright and pleasant surroundings, by variation of the patient's routine, and by moral stimulation. An attempt should be made to occupy the patient's attention during every waking hour; experience has shown that the average patient stay in hospital is shortened materially where this can be done. Diversional and recreational programs have proven so effective in this respect that they are considered, by some, to be a form of therapy. Though impressed with the results, official medical circles have not yet classified recreation as a therapeutic service. It is a possible explanation for this attitude that few hospitals can afford a diversional or recreational program and so have been unable to observe its benefits at first hand. In staff planning, such a program means personnel, and whether the workers be volunteers or paid professionals, the

Reprinted from the "Treatment Services Bulletin," July, 1949. One of a series of articles on hospital staff planning by the same author.

hospital staff establishment is increased in consequence.

Rehabilitation

The rehabilitation of the sick and disabled is by far the most important innovation in medicine that has occurred in recent times. Medical rehabilitation is still in its infancy and, though the public demand for it is great, there is no unanimity of opinion as to who should be responsible for carrying out and co-ordinating the details of its extensive program. It has been approached as a social problem to be dealt with by the community and as a medical responsibility to be assumed by hospital services. The community is concerned because medical rehabilitation is a matter of public interest; the hospital is concerned because medical rehabilitation, in the first instance, must begin with the patient's admission to the hospital or there can be little hope of success. It is of the greatest importance in staff planning because it affects almost every service in the hospital, necessitating adjustments to meet increased responsibilities.

Adaptation of the patient must begin at once for delay reduces prospects of rehabilitation. Initially, the treating physician must prevent a decline in the patient's morale by reassuring him that a reasonably useful future lies ahead. The patient's confidence must be gained and his interest stimulated in the program of rehabilitation. Despite the efforts of the physician, an acute depression may set in, requiring the services of a psychiatrist. The mental aspects of the disease must be treated before anything else is attempted. The medical social service can also provide useful background information at this stage and secure co-operation of the patient's family. A psychological assessment of the patient's aptitudes for new occupations should also be obtained in order to reduce wasted effort. It would be a loss of time to proceed with a course of rehabilitation for which the patient shows neither aptitude nor inclination.

Vocational Counsellor.

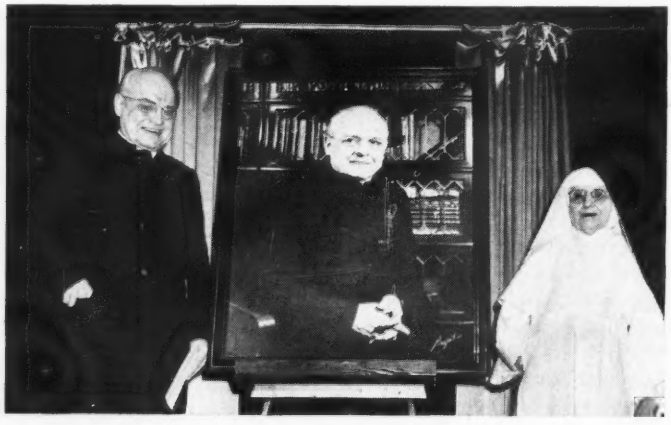
Aware of the physician's prognosis, the psychiatrist's opinion, the psychologist's assessment, and the social background, the vocational counsellor may then confer usefully with the patient about his future plans. The first few interviews may be fruitless for the patient requires some time to realize that the old order has changed and that he must adapt himself to new horizons. It is never easy for a person to change the habits of a lifetime and the patient may be confused and bewildered. The vocational counsellor must exercise the utmost patience and understanding at this stage. The choice of a new vocation is necessarily limited by the availability of jobs. It is of little use to choose an occupation for which there is no demand. A reasonable guarantee of employment must be given to the patient and this requires a considerable amount of field work on the part of the vocational counsellors who spend much time outside of the hospital making industrial and business contacts for the benefit of their patients.

The patient's goodwill and co-operation obtained, reorientation begins in the hospital while he is still undergoing treatment. This is the stage of re-education and retraining. A wide range of subjects must be available in a retraining program if any appreciable number of patients are undergoing rehabilitation. Such a program employs an imposing array of specialists ranging from master mechanics to music teachers. Accommodation and equipment must be provided together with administration to co-ordinate them. The rehabilitation of the patient, once begun in the hospital, must be continued after the patient's discharge and during his convalescence. The post-discharge period is crucial, requiring close supervision of the patient and his surroundings. During this phase, the welfare services play a decisive part for it may be necessary to give the patient economic assistance until he reaches the stage of full employment. Thus rehabilitation requires physicians, psychologists, medical social workers, vocational counsellors, educational specialists, and welfare agents, not to mention the administration necessary to co-ordinate the program.

Finance

A rehabilitation program imposes a tremendous financial burden on those who undertake it. Most hospitals are loath to try it, preferring to hand it over to the community social agencies as a socio-economic problem. This attitude is, no doubt, engendered by the unfavourable financial position in which most hospitals find themselves today; they simply cannot undertake more services on their present budgets. The community social agencies, though willing, are not competent to control the initial stages of the program which are so essential to its success. If the problem is to be solved at all, it must be approached as a co-operative enter-

(Concluded on page 110)



C.H.A. Honours Father Schwitalla

Following the general opening session of the recent Catholic Hospital Association Convention, a reception was held in honour of the Rev. Alphonse M. Schwitalla, S. J., past president of the Association. A feature of the event was the unveiling of a life-size portrait of Father Schwitalla by Mother M. Eugenia, O.P., of Mary Immaculate Hospital, Jamaica, L.I., N.Y.

The Hobby Corner

15. R. H. Macdonald, M.D.

IN the opinion of Dr. R. H. Macdonald, chief of staff and surgeon at St. Paul's Hospital, Saskatoon, everyone, particularly medical men, should develop a hobby and no hobby is more valuable than breeding animals, where one can obtain much practical information including a knowledge of genetics. The hobby need not be a costly one; until a few years ago, ranching fur-bearing animals returned good profits.

Dr. Macdonald became interested in fur farming in 1926, beginning with foxes and adding mink about six or eight years ago. While his ranch is of only moderate size he has raised as many as 600 foxes at one time, although at present the number has been reduced in favour of an increase in mink. Today he ranches about 1000 mink and 300 foxes. In addition to the more usual silver foxes, platinum, pearl platinum, and white face foxes are also raised on the farm.

"There is a satisfaction", Dr. Macdonald maintains, "in producing outstanding animals and I personally look after the individual matings. No matter what animals one may be raising, if one wants to produce top quality, it cannot be done by indiscriminate and happy-go-lucky breeding. All animal breeding, particularly that of mink, demands a knowledge of genetics. For example, this year I produced three new type mink, the result of mating two recessives together and then mating the progeny of these; a new type mink, one in sixteen, is produced in this way."

For the number of times he has shown at live-stock exhibitions, Dr. Macdonald has probably won more ribbons than any individual breeder in Canada. At five out of the six or seven shows at which he has exhibited, he has won the Grand Championship for foxes and has also won championships and ribbons for his mink in the past few years. As far back as 1933, he topped the world's market in London, England, for the best silver fox pelt sold at auction, there being 137,000 silver fox pelts. The basement of his home is crowded with cups and trophies won at livestock shows of both mink and foxes.

"My ranch is only a few minutes from Saskatoon", Dr. Macdonald points out, "and, besides making one more or less expert in judging all types of foxes and mink, it is wonderful relaxation from a busy surgical service."

Dr. Macdonald and a Platinum Fox Pup

Highlights on

Compulsory Hospital Insurance

in British Columbia

Percy Ward,

Secretary, British Columbia Hospital's Association, Vancouver, B.C.

The Advent:

THE residents of British Columbia commenced paying compulsory hospital insurance premiums on 1st October, 1948. The Government hospital insurance plan became effective on 1st January, 1949.

What the people pay:

Single person with no dependents ..... $15 per annum
One person with one dependent ..... $24 per annum
One person with more than one dependent $30 per annum

What the governments pay:

Each municipal government (except villages) pays into the insurance fund 70 cents per day for each day's treatment in respect of its own legal residents. The Provincial Government pays approximately 70 cents (sliding scale) per day in respect of all days' treatment irrespective of legal residence. The Provincial Government pays the insurance premiums in respect of all persons in receipt of social assistance.

What the people receive:

Unlimited necessary in-patient care for acute illness, plus out-patient care in emergencies, and use of the operating room. Radiology and pathology are included in hospitals which employ radiologists and pathologists on a salary basis.

What the hospitals receive:

An inclusive rate calculated by Hospital Insurance Service to cover the cost of public ward care to in-patients in each hospital. That portion of the rate representing depreciation to be placed in a separate bank account and spent only with permission.

How the rate is calculated:

(Each hospital rate is calculated separately).

Total operating expenditure, inc. depreciation.. .....
Plus a variable percentage to cover contingencies .....

Grand Total .....

Less expenditures in respect of out-patient services, except as above ....
Less receipts from extra charges, over and above public ward costs, from private and semi-private rooms .....

Total expense of public ward care (1).....

NOTE: (1) divided by in-patient days treatment equals the rate. Hospital Insurance Service pays that rate in respect of insured persons. The hospital is ordered to charge the same rate to uninsured persons.

Different rates in different hospitals:

Rates paid to hospitals vary from approximately $5 per day to over $13 per day.

W. C. B. and Indians:

Since 1st September, Workmens' Compensation Board patients have been re-insured through the Provincial Hospital Insurance Service. Indians who are wards of the Dominion Government are covered.

How the Plan is administered:

The Hospital Insurance Act is administered by the Minister of Health and Welfare. Hospital Insurance Service is headed by the Hospital Insurance Commissioner who has the status of a Deputy Minister. There has been set up a Hospital Advisory Council which is supposed to meet at least every three months. The members represent the hospitals, the medical profession, the municipalities, and the registered nurses. The Hospital Insurance Commissioner is the chairman and his executive assistant is the secretary.

Capital construction and expansion:

Not covered by the Hospital Insurance Fund. The Provincial Government looks to voluntary groups to take the initiative. The Province grants one-third of the building cost plus $1,000 per bed from the Dominion Government. Municipal governments and voluntary groups to raise the remainder.

Progress to date:

There are still many problems to solve. Hospital costs have risen materially since 1st January, 1949, mostly due to increases in salaries and wages. The Provincial Premier recently stated through the press that it is calculated there will be a deficit of approximately $3,000,000 in the first year of operation. Increases in the premiums to be paid by the public were predicted. (The published prediction hints a 40 per cent increase for single persons; a 36.7 per cent increase for one person with one dependent, and a 10 per cent increase for families.)

(See p. 60)

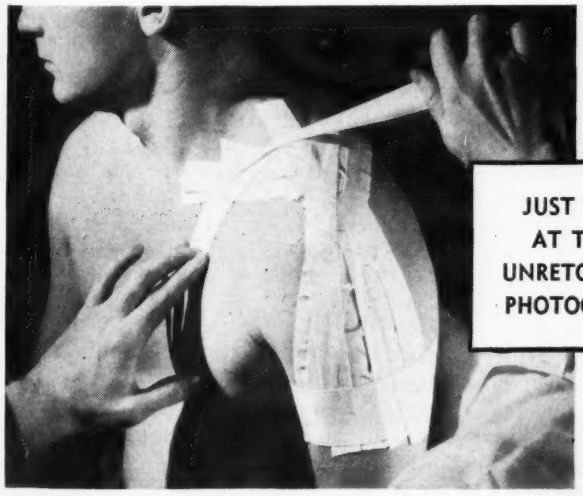
It's not just the adhesive . . .
It's the kind of cloth the adhesive is on

NO WRINKLE...
NO CRINKLE...NO CURL

As you know, CURITY Adhesive Tape has long been known for its "stick-to-it-iveness" and lack of skin irritation. But equally important, CURITY adhesive is made with a special cloth backing which makes it easier — far easier — to handle.

If you have ever been slowed down because limp, droopy tape wrinkled or stuck to itself as you applied it, just try a roll of CURITY. See for yourself how the special cloth backing of CURITY adhesive gives it more "body" — makes it easier to handle because it goes on smoothly, lies flat.

What's more, the same special cloth that makes CURITY adhesive easier to apply also reduces stretching, gives longer support . . . you have to retape less frequently with CURITY adhesive.



Here is the kind of wrinkling difficulty you encounter, to a greater or lesser degree with ordinary tapes.

JUST LOOK AT THESE UNRETOUCHED PHOTOGRAPHS

Note the smooth application of CURITY adhesive because of the special CURITY cloth.

*REGD. IN CANADA

BAUER & BLACK

Division of the Kendall Company (Canada) Limited, Toronto, Ontario

Curity
REG. IN CANADA

Sales Tax Interpretation Clarifies Hospital Procedures

THERE has been some confusion in the hospital field concerning the conditions whereby a hospital can obtain certain supplies tax free under the exemption certificate and at the same time obtain other supplies, such as certain drugs, for resale to patients upon which the tax can be paid at the time of purchase rather than after sale to the patient.

During recent months a number of hospitals have signified to the government their intention of paying the sales tax on purchases of drugs, medicines, et cetera, in order to avoid the necessity of accounting for the tax on their taxable charges to patients or others for the goods. Some hospitals have noted the economy of paying the sales tax at the time of purchase rather than on the sale price to the consumer, which would obviously mean a larger tax.

Hospitals have had available to them two alternate procedures. The generally adopted measure, which is the one outlined in the *Canadian Hospital Council Bulletin No. 49*, pages 16 to 23, permits the hospital to use its special sales tax exemption certificate to obtain taxable items free of sales tax on condition that for those drugs supplied to patients at a charge exceeding 10 per cent of the cost price a quarterly return to the government be made, remitting sales tax on such sales to patients and others. This arrangement is a simple one and would seem to meet with the approval of the government, provided accurate records are kept and sales tax remitted quarterly. A number of hospitals have been in difficulty with the Department of National Revenue because they have not kept these records or made the quarterly return.

On the other hand a number of hospitals may desire to follow the procedure already mentioned above whereby the sales tax is paid at time of purchase on those articles which may be resold to patients. On this point Mr. V. C. Nauman, Assistant Deputy Minister of National Revenue, has ruled:

"Hospitals adopting this procedure are required to discontinue quotations of their sales tax exemption certificates on purchase of all drugs, medicines, or other therapeutic or pharmaceutical products, any portion of which is intended for resale to patients or others, as it is considered that any attempt by a hospital to purchase tax-paid the portion of such goods intended for resale to patients or others, and at the same time to purchase under its exemption certificate the portion thereof intended for the sole use of the hospital and not for resale, would lead, inevitably, to confusion with its suppliers. Moreover, it would not be possible for the Department to consider favourably any claim by the hospital for refund of the sales tax paid at the time of purchase of the portion of such goods that subsequently may be used by the hospital and not resold."

Ruling indicates conditions under which certain purchases can be sales tax free and sales tax prepaid on other supplies.

The above paragraph makes it very clear that if a certain article, such as cough medicine, is to be used both for patients to whom a charge will be made and for patients to whom no charge will be made, it is not possible for the hospital to order double stocks, one of which would be tax-paid and the other tax exempt. Mr. Nauman has ruled, however, that for certain other articles for general use in the hospital and for which no special charge would be made to any patient the sales tax would not be applicable. This arrangement would thus permit a hospital to buy certain commodities tax paid and others tax exempt but not two separate stocks of the same commodity. Mr. Nauman's ruling follows:

"Where ether, chloroform, ethyl chloride, oxygen, nitrous oxide, carbon dioxide, cyclopropane and pentothal-sodium or other anaesthetics, bandages, dressings, tape, sutures or other materials are used during operations and are included in the charge made for the use of the operating room or case room, no sales tax would be applicable as the material would not be considered as having been resold. Such materials, therefore, can continue to be purchased by the hospital without payment of sales tax under its exemption certificate, as can also green soap, baby soap, lubricating jelly, Lysol or any other disinfectants, since these materials are considered as hospital supplies and are not charged to patients."

Mr. Nauman adds further: "Alcohol for rubbing purposes or for sterilizing . . . . is considered as coming within the category of hospital supplies and, likewise, can continue to be purchased by the hospital without payment of sales tax under its exemption certificate."

Coupled with this ruling, we are assured that the rulings and interpretations as given in the *Canadian Hospital Council Bulletin No. 49*, dealing with legislation, remain unchanged.

New Method of Mailing "The Canadian Hospital"

Last month we adopted the method of applying the address directly to the cover of The Canadian Hospital. The new system, which is used extensively by other publishers, offers these advantages: it is less expensive, as it eliminates wrappers and wrapping; it lessens the work of our business office staff; it permits delivery without the objectionable folding of the magazine.

If copies, at any time, are not received at your office in a satisfactory condition, we would appreciate it if you would advise the business office of *The Canadian Hospital* at 57 Bloor Street West, Toronto.

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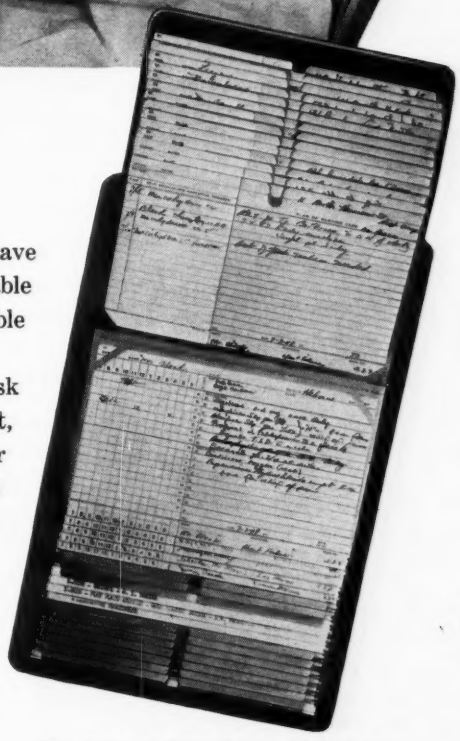

The hours of treatments are checked on the visible margin of each card at Presbyterian Hospital so that a single swift glance tells the nurse which patients require medication or treatment at any given time. Above the margin on each card are the doctor's instructions opposite the designated hour.

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Royal Commission Reports on Windsor Hospital Probe

JUDGE Eric W. Cross, appointed by provincial order-in-council to investigate the administration of the municipally-owned Metropolitan General Hospital at Windsor, Ont., has submitted his report to the City of Windsor. This investigation, requested by the City, had been held because of criticism of the administration and the circumstances leading up to the resignation of the director of nursing, Miss Mildred Maybee.

The Detroit "Party".

In his investigation the Commissioner had dealt early with the "party" across the river in Detroit which had been attended by the superintendent, Mr. Horace Atkin, Mayor Rheaume of Windsor and four pupil nurses from the hospital. After reviewing this episode in his 12,000-word report, Judge Cross stated: "The evidence concerning the whole evening disclosed no improprieties, no immoderation in food nor drink, no light amours nor scenes of passion. To the scandal seekers, it was almost unbelievably dull." He did find, however, that "it was improper and indiscreet for them (Mr. Atkin and Mayor Rheaume), both married men, to entertain unchaperoned in a suite in a Detroit hotel four nurses from the hospital where one was the chief executive officer, and the other a member of the Board of Governors".

This action, he held, was not in the best interests of the hospital because it undermined internal discipline and injured the good name of the hospital.

Noting that Mr. Atkin's conduct was "wholly improper" and was harmful to the hospital, he had already recommended to the Board the immediate dismissal of Mr. Atkin. Mr. Atkin, however, submitted his resignation and this had been accepted. Apart from these indiscretions, the Commissioner stated, Mr. Atkin had "fulfilled his duties as administrator conscientiously and with reasonable competence".

With respect to Miss Maybee, Judge Cross stated that she "emerged with her reputation unscathed and her course of conduct in the main vindicated".

Medical Services

The medical services had been criticised, but the Commissioner found that "All the evidence before me establishes that the medical services . . . . have been and are on a high level worthy of public confidence." He quoted from Dr. Harvey Agnew's report to the Commission: "The excellent over-all results obtained at the hospital would indicate a high average level of competence and performance."

Judge Cross concurred with ten recommendations made by Dr. Agnew.

1. Prescribed rules should be better observed—history writing, written pre-operative diagnoses, et cetera.
2. Hospital organization should be clarified and staff by-laws revised without delay.
3. Dental appointments should be recognized.
4. The staff executive and heads of departments should confer regularly during the summer months.
5. The by-law respecting attendance of active staff members at meetings should be observed.
6. The ruling respecting delinquency in the writing of histories should be stiffened considerably.
7. Regulations and standing orders respecting the care of patients should be reviewed and amplified when necessary.
8. The *Standard Nomenclature* of diseases should be adopted.
9. Much thought should be given to the possible scope of the hospital's activities. A social service development is needed. There is need for accommodation for the chronically ill on the grounds of the general hospital. More diagnostic service might be considered.
10. The five Windsor hospitals should set up a superintendents' conference or a local hospital council.

Administration

The Commissioner also supported the evidence of Mr. A. J. Swanson of Toronto on the administration. Mr. Swanson noted the lack of proper inventory control, of adequate storage facilities, and of improved methods of purchasing with more competitive prices and better records.

Mr. Swanson found "a complete lack of policy as regards personnel and their basis of employment". He found, however, a very excellent type of personnel, thoroughly conscientious and loyal to the hospital.

Nursing

Praise was given also to the nursing staff. Special mention was made of the School of Nursing under Miss Fidler. Miss Gladys Sharpe, called in as consultant on nursing, had been critical of certain standards, but the Commissioner was inclined to overlook them in view of Miss Maybee's resignation and the turmoil of recent months.

Finance

The deficits in recent years were reviewed in the report. Attention was focussed on the fact that the citizens of Windsor are suffering considerable loss by caring for county patients at much less than cost. "A great injustice has been and is being done the citizens of Windsor." And later, "a plain moral obligation rests upon the county" to pay additional sums for the care of its indigents. Noting the "indifference" of the county council, the Judge remarked: "I am afraid they may prefer to pass by on the other side while the samaritans of Windsor tend the county sick." He recommended legislation permitting a municipally owned hospital to charge its actual cost for indigent care to outside municipalities.

Board of Governors

A special committee of the Board should be set up to revise the by-laws. The channeling of authority should be clarified. Four standing committees should be set up by the Board —management, finance, property, and building.

The Commissioner recommends a

(Concluded on page 106)

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Record Number of Admissions at A.C.H.A. CONVOCATION

AT its 15th annual meeting and convocation ceremony, which was held in Cleveland on September 24th to 27th, the American College of Hospital Administrators admitted to its ranks 205 Nominees; 115 were advanced to Membership and 19 to Fellowship. Honorary Fellowships were conferred upon three distinguished members of the profession. These were: Claude W. Munger, M.D., a former president of the A.C.H.A. and of the A.H.A., and former director of St. Luke's Hospital, New York City; Rev. John W. Barrett, president of the Catholic Hospital Association of the United States and Canada, president of the Chicago Hospital Council, and a former trustee of the A.H.A.; Miss Mary M. Roberts, Reg.N., editor-in-chief of the American Journal of Nursing 1921-1949, a former president of the Ohio State Nurses' Assoriation, and an active member of the American Nurses' Association, and of the League of Nursing Education.

Convocation was held on Sunday afternoon, followed by the President's reception. In the evening, the 15th A.C.H.A. banquet preceded the first Arthur C. Bachmeyer annual address, given by Stuart Chase, author and economist. Graduates of Dr. Bachmeyer's course in hospital administration at the University of Chicago have made this annual address possible by underwriting it as a tribute to Dr. Bachmeyer.

The general educational session on Monday, under the chairmanship of Miss Jessie Turnbull, President, had as its theme "The Governing Board and the Administrator". Challenging addresses on different phases of this subject were given by Edward K. Warren, president of the Board of Directors, Greenwich Hospital Association, and John Calhoun Baker, President of the University of Ohio.

Succeeding Miss Jessie Turnbull, Dr. Wilmar M. Allen, director of Hartford Hospital, Hartford, Conn., was elected President of the A.C.H.A. for the coming year. The president-elect is Frank J. Walter, administrator, Good Samaritan Hospital, Portland, Ore. The new first vice-president is Clyde L. Sibley, superintendent, Baptist Hospital, Birmingham, Ala., and second vice-president is Edna H. Nelson, administrator, Women's and Children's Hospital, Chicago. Dr. A. F. Anderson of Edmonton succeeds the late Alexander Esson as Regent for Western Canada while R. Fraser Armstrong of Kingston continues as Regent for Eastern Canada.

Canadians Admitted or Advanced

Among the large numbers admitted to the College or advanced this year, Canada was well represented. The names of Canadians so honoured are as follows:

Advancement to Fellowship:

Sister Mary Veronica, Saint John, New Brunswick.

Advancement to Membership:

Sister Anita Vincent, Halifax, N.S.
Sister Annette Lachance, Saskatoon, Sask.
J. Ralph Boutin, M.D., Montreal, Que.
Donald R. Easton, M.D., Edmonton, Alta.
Walter Hatch, Montreal, Que.
Mother Margaret Catherine, Toronto, Ont.
Sister M. Louise Carey, Toronto, Ont.
Sister Mary of the Nativity, Winnipeg, Man.
Murray William Ross, Edmonton, Alta.
Sister St. Adolphe, Quebec, Que.

Nominees Admitted:

Sister Catherine Gerard, Halifax, N.S.
Sister Eugenie Choquette, Saint-Jean, Que.
George E. Masters, Vancouver, B.C.
George W. Peacock, M.D., Kingston, Ont.
Sister St. Christine, Edmonton, Alta.
Sister St. Joseph, Bathurst, N.B.
Sister Saint Marien (Thiboutot), Rimouski, Que.
John E. Sharpe, M.D., Toronto, Ont.
Eugenie M. Stuart, B.S.H.A., Toronto, Ont.

Dr. Claude Munger Receives A.H.A. Award of Merit

The American Hospital Association has announced the presentation of its 1949 Award of Merit to Dr. Claude W. Munger, former administrator of St. Luke's Hospital in New York, N.Y.

It is customary to make this presentation during the A.H.A. Convention but owing to Dr. Munger's illness the award was officially presented, prior to the Convention, by the President, Joseph G. Norby, and George Bugbee, executive Secretary of the A.H.A. The President read this citation:

"Claude Worrell Munger, eminent administrator and counsel whose energy and wisdom have immeasurably advanced education and standards of hospital administration and whose selfless leadership of hospitals, health organizations, and the American Hospital Association have benefited all people."

Dr. Munger is a past-president of the American Hospital Association and has served on the Board of Trustees. He is also a former president of the American College of Hospital Administrators. He is the eleventh recipient of the Award of Merit, which is presented to association members who have made noteworthy contributions in the realm of hospital administation. •

Mary Johnson Assigned to A.C.H.A. Education Post

At the banquet of the American College of Hospital Administrators on September 25th, Mary Johnson was named the first co-ordinator of post-graduate education in hospital administration.

Miss Johnson's appointment was another step forward in the association's five-year educational program to raise the level of efficiency in hospital administration. According to Miss Jessie Turnbull, this appointment is an essential move in implementing the program.

As an instructor in hospital administration at Columbia University, Miss Johnson has had valuable experience in planning educational programs and is a qualified hospital administrator.

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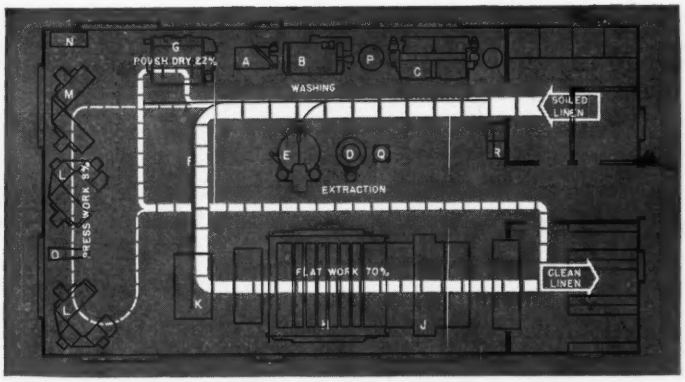

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Library Service

IN addition to the publications listed in our September issue, the following books and manuals are also available for reference or on loan from the Canadian Hospital Council library.

In response to specific inquiries, articles and other relevant material, collected from various sources, will be assembled in package libraries and forwarded as soon as possible.

Futher available publications and additions to the library will be listed in this journal from time to time.

Administration and Construction

HOSPITALS — INTEGRATED DESIGN. Pp. 308. 1947. Isadore Rosenfield. Reinhold Publishing Corp., New York.

ON HOSPITALS. Pp. 395. 1947. Sigismund S. Goldwater. The MacMillan Company of Canada, Toronto.

THE AMERICAN HOSPITAL. Pp. 226. 1946. E. H. L. Corwin. Commonwealth Fund, New York.

THE HOSPITAL BUILDING. Pp. 71. 1948. A compilation of lectures delivered at the 1947 Convention of the American Institute of Architects, with a comprehensive bibliography for these lectures, covering hospital developments, design, planning and other construction details.

DESIGN AND CONSTRUCTION of General Hospitals. Pp. 112. 1949. Modern Hospital Publishing Co., Chicago. This series of articles appeared in *Modern Hospital* in March, 1947, and succeeding months, under the title, "The Functional Basis of Hospital Planning" and are brought up to date in this publication.

DESIGN AND EQUIPMENT of Hospitals. Pp. 360. 1949. Ronald Ward. Ballière, Tindall & Cox, London, W.C. 2.

PLANNING AND CONSTRUCTING the General Hospital. Pp. 43. 1945. Canadian Medical Association.

COMMUNITY CLINICS. Pp. 276. 1947. Loretta I. Bigley, Reg.N. J. B. Lippincott Co., Montreal.

PROBLEMS OF HOSPITAL ADMINISTRATION. Pp. 106. 1948. Charles E. Prall. Physicians Record Co., Chicago.

COLLEGE CURRICULUM in Hospital Administration. Pp. 107. 1948. Report of the Joint Commission on Education. Physicians Record Co.

TECHNIQUE OF EXECUTIVE CONTROL. Sixth Edition. Pp. 270. 1946. Erwin Haskell Schell. McGraw-Hill Book Co., Toronto.

PAPERS ON THE SCIENCE OF ADMINISTRATION. Pp. 189. 1939. Luther Gulick and L. Urwick. Columbia University, New York.

MEDICINE IN THE CHANGING ORDER. Pp. 240. 1947. New York Academy of Medicine. Committee on Medicine and the Changing Order, New York.

ADMINISTRATIVE MEDICINE. Pp. 839. 1941. Haven Emerson, M.D. Thomas Nelson and Sons, New York.

SMALL COMMUNITY HOSPITALS. Pp. 182. 1944. Southmayd and Smith. Commonwealth Fund, New York 22, N.Y.

Nursing

MEASURING NURSING RESOURCES. Pp. 117. 1949. Prepared by Lois E. Gordner, Nurse Officer, Public Health Services, Federal Security Agency, Washington.

NURSING FOR THE FUTURE. Pp. 198. 1948. Esther Lucile Brown. Russell Sage Foundation, New York.

NURSING IN MODERN SOCIETY. Pp. 288. 1947. Mary Ella Chayer, Reg.N. G. P. Putnam's Sons, New York.

THREE CENTURIES OF CANADIAN NURSING. Pp. 505. 1947. John Murray Gibbon and Mary S. Mathewson, Reg.N. The MacMillan Co., Toronto.

LAW AND THE PRACTICE OF NURSING. Pp. 106. 1947. Nettie D. Fidler, Reg.N., with Kenneth G. Gray, M.D. The Ryerson Press, Toronto.

THE PRACTICAL NURSE. Pp. 370. 1947. Dorothy Deming, Reg.N. Commonwealth Fund, New York.

PROFESSIONAL RELATIONSHIPS of the Nurse (Second Edition). Pp. 427. 1947. Helen F. Hansen, Reg.N. W. B. Saunders Co., Philadelphia. (McAinsh, Toronto.)

GYNECOLOGY and Gynecologic Nursing (Second Edition). Pp. 485. 1949. Norman F. Miller, M.D. and Betty Hyde, Reg.N. W. B. Saunders Co., Philadelphia.

PEDIATRIC NURSING. Pp. 638. 1948. Gladys S. Benz. The C. V. Mosby Co., St. Louis.

ILLUSTRATED HANDBOOK of Simple Nursing. Pp. 238. 1949. Wava McCullough (assisted by Marjorie Moffat, Reg.N.). McGraw-Hill Book Co., New York and Toronto.

Accounting

ACCOUNTING, STATISTICS and Business Office Procedures for Hospitals. Pp. 287. 1946. Charles G. Roswell. United Hospital Fund, New York.

REPORT OF JOINT COMMITTEE on Hospital Accounts. Pp. 67. 1948. Institute of Hospital Administrators, London, S.E. 1.

ACCOUNTING MANUAL for Public Hospitals of the Province of Ontario. Pp. 80. 1948. Ontario Department of Health, Toronto.

INSTITUTIONAL COST ACCOUNTING. Pp. 153. 1944. Public Administration Service, Chicago.

HOSPITAL ACCOUNTING AND STATISTICS. Pp. 157. 1940. (A manual with special reference to smaller hospitals.) American Hospital Assoc., Chicago.

Miscellaneous

RURAL HEALTH AND MEDICAL CARE. Pp. 610. 1948. F. D. Mott, M.D., and M. I. Roener, M.D. McGraw-Hill Book Co., New York and Toronto.

STANDARDS AND RECOMMENDATIONS FOR HOSPITAL CARE OF NEWBORN INFANTS. Pp. 55. 1949. Committee on Fetus and Newborn. The American Academy of Pediatrics, Evanston, Ill.

BETTER HOSPITAL CARE for the Ambulant Patient. Pp. 184. 1946. Hospital Assoc. of Pennsylvania, Harrisburg, Pa.

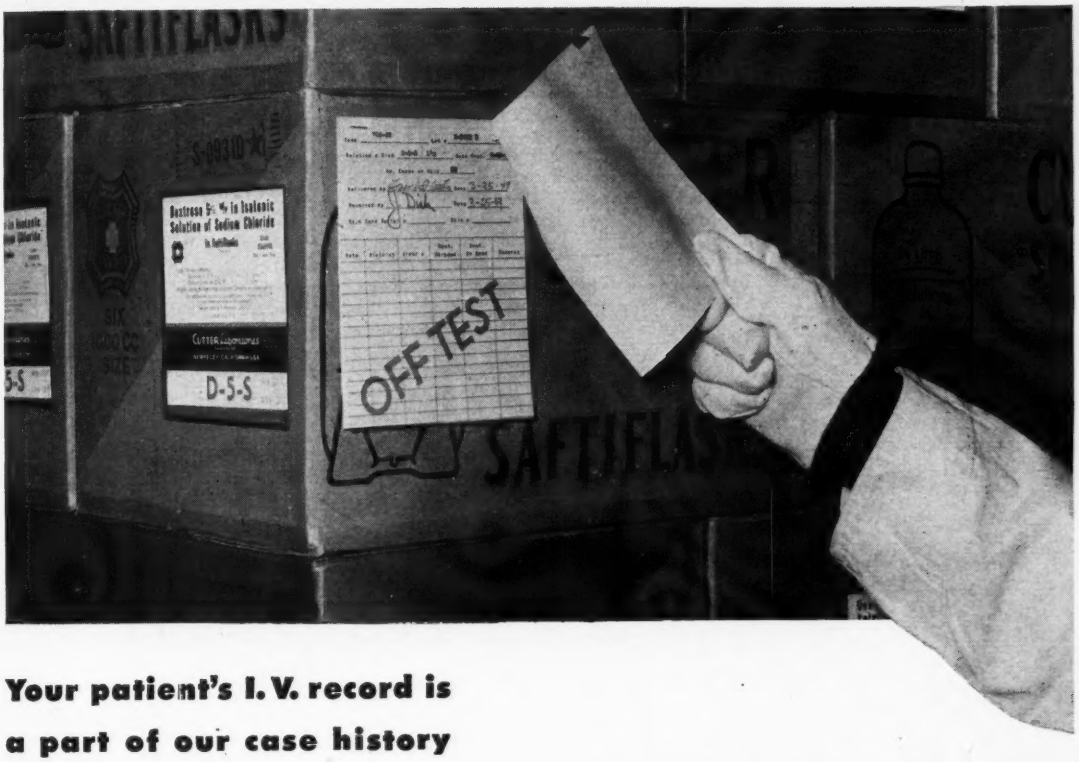
MEDICAL CARE of the Discharged Hospital Patient. Pp. 94. 1944. Jensen, Weiskotten and Thomas. Commonwealth Fund, New York.

ANAESTHESIA PRINCIPLES AND PRACTICE. Pp. 148. 1949. Alice M. Hunt, Reg.N. G. P. Putnam's Sons, New York.

PHYSICAL THERAPY, Essentials of a Hospital Department. Pp. 37. 1949. American Hospital Assoc., Chicago.

MANUAL FOR HOSPITAL LIBRARIANS. Pp. 120. 1947. C. E. A. Bedwell. The Library Association, London, Eng.

FILE UNDER CASE HISTORY



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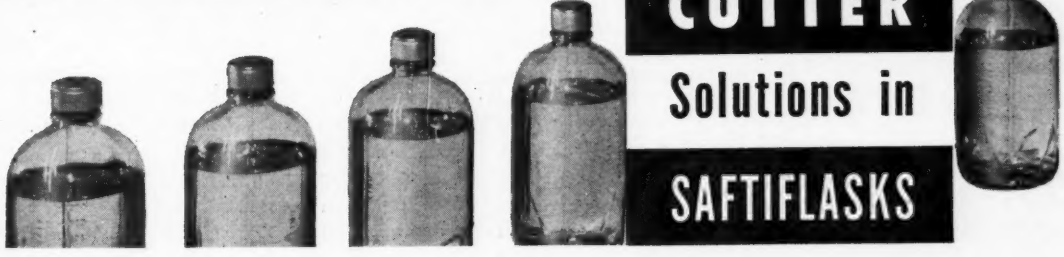

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MANUAL OF HOSPITAL STANDARDIZATION. Pp. 118. 1946. American College of Surgeons, Chicago.

COLOUR CONDITIONING FOR HOSPITALS. Pp. 52. 1949. Canadian Industries Limited, Toronto.

HOSPITAL COLOUR AND DECORATION. Pp. 253. 1944. Raymond P. Sloan, Physicians Record Co., Chicago.

MAYO CLINIC DIET MANUAL. Pp. 329. 1949. Committee on Dietetics of the Mayo Clinic. W. B. Saunders Co., Philadelphia.

PATTEE'S DIETETICS. Pp. 736. 1945. Alida Frances Pattee. G. P. Putnam's Sons, New York.

DISINFECTION OF AIR. Pp. 22. 1947. Committee on Air Sterilization and Conditioning. American Hospital Assoc., Chicago.

N.F.P.A. HANDBOOK of Fire Protection (Tenth Edition). Pp. 1544. 1948. National Fire Protection Assoc., Boston.

INTERNATIONAL STATISTICAL CLASSIFICATION of Diseases, Injuries and Causes of Death. Pp. 376. 1948. Dominion Bureau of Statistics, Ottawa.

STANDARD NOMENCLATURE of Diseases and Standard Nomenclature of Operations. Pp. 1022. 1942. Edited by Edwin P. Jordan, M.D. American Medical Assoc., Chicago.

HOSPITAL ADMISSIONS AND RECORDS, Some Observations. Pp. 28. 1948. King Edward's Hospital Fund for London. Geo. Barker and Son, Ltd., London, Eng.

HANDBOOK FOR DISCUSSION LEADERS. Pp. 118. 1947. John Jeffery Aver and H. L. Ewbank. Harper Brothers, New York.

ASEPTIC TREATMENT OF WOUNDS. Pp. 372. 1948. Carl W. Walter, M.D. MacMillan Co., New York and Toronto.

PHYSICIANS FORMULARY. Pp. 120. 1946. Compiled by C.M.A. Committee on Pharmacy. University of Toronto Press.

CANADIAN ELECTRICAL CODE. Part I. Fifth Edition, 1947. Pp. 330. Canadian Standards Association.

Book Reviews

THE HOSPITAL GOVERNING BOARD. By J. Dewey Lutes, F.A.C.H.A., Director of the University Hospital, Augusta, Ga. Foreword by Dean G. Lombard Kelly, University of Georgia School of Medicine. Pp. 55. Tidwell Printing Supply Co., Augusta, Ga. 1949.

This work has obviously been based upon many years of experience with boards of hospitals. The author is well equipped to write upon this subject, for he has not only had an extensive personal experience from which to draw, but has also had many opportunities to broaden his contacts through his work in local and national associations. Mr. Lutes, it will be recalled, was a founder and the first executive secretary (then entitled secretary - general) of the American College of Hospital Administrators.

Trustees and the executives with whom they work will find this volume both interesting and beneficial. It is not a complete treatise on the subject and leaves many points untouched or dealt with in a general way only. Views are not expressed, for instance, on the size of boards, on the ways of obtaining responsible medical representation, or the conducting of meetings or the various subcommittees. It does, however, deal effectively with such major points as the qualifications of the trustee, the method of his appointment, and his relationship to the administrator and to the administrator's accepted prerogatives. A helpful chapter on the appointment of an administrator and on the present training programs for administrators has been contributed by Dr. Edgar C. Hayhow. The general tone of the volume is conversational and personal rather than didactic, thus making it all the more readable to the busy trustee.

TABLET MAKING. By A. Little and A. K. Mitchell. Pp. 121. 41 Illustrations. Published by the Northern Publishing Co., Ltd., 37 Victoria St., Liverpool, Eng. 1949. 15 Shillings.

A review of this volume reveals a concise and well written text, giving a complete technical description of tablet making for every branch of pharmacy, from the requirements of the dispensing store and small hospital to those of the very large hospital and commercial plant. All stages of tablet manufacture, mixing, granulating, drying, compressing, colouring, and coating, are described in detail, chapters being devoted to each of these headings. A weights and measures table and glossary of terms, as well as a complete index, are included. Reasons for various types of failures are outlined with suggestions for the elimination of the cause of each type. The numerous illustrations of equipment are in fine detail. Twenty-five formulae, representing the various types of tablets in use, are listed with directions for their manufacture.

This very excellent text should prove a welcome addition to the library of anyone manufacturing tablets, or contemplating the procedure, and of value to all others in the field of pharmacy to bring them up-to-date on the problems and improvements in tablet making.—*P.C.S.*

THE DESIGN AND EQUIPMENT OF HOSPITALS. By Ronald Ward, F.R.I.B.A., F.I.Arb., M.R.San.I. With Forewords by Sir W. Allen Daley, J. P. Wetenhall and Fredk. R. Hiorns. Pp. 360. Profusely illustrated with halftones and line drawings. $10.50. Published by Baillière, Tindall and Cox, London, W.C.2. Agents, MacMillan Company of Canada. 1949.

This pretentious volume will be of much value to those connected with hospital design and construction. It is essentially practical in its approach and reveals much knowledge of the functional problems of hospitals. It is evident also that the author is quite familiar with construction practices and trends on this continent. The volume deals with: General Considerations, such as site and layout; Administrative Considerations, such as communications, the service departments and residences; Medical Considerations, wards, operating rooms, laboratories, et cetera; Special Wards, such as private, maternity, isolation and psychiatric; Special Hospitals; and various factors in Construction, e.g. building techniques, materials and costs.

The author refers to the rival schools of vertical and horizontal planning, the former prevailing in America and the latter in Great

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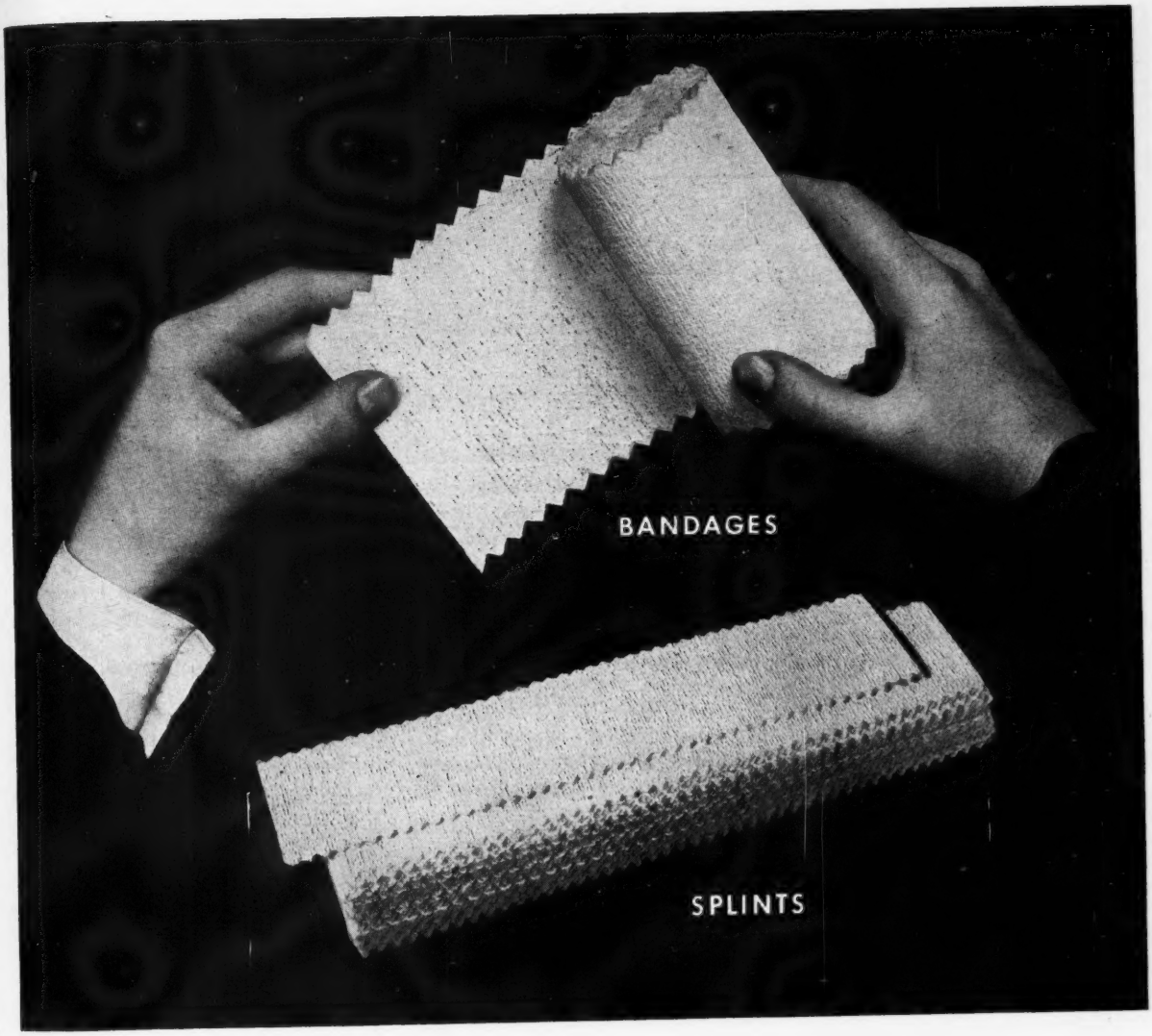

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Notes on Federal Grants

Cancer Control

Two hospitals in Quebec have been allotted more than $37,000 to extend the work of their anti-cancer centres. The grant to St. Vincent de Paul General Hospital, Sherbrooke, will be used to purchase technical equipment needed for the early diagnosis and treatment of cancer. The federal grant to St. Sacrement Hospital, Quebec, will pay one half the salaries of an additional nurse, a technician, and a secretary, and half the cost of a large quantity of technical equipment for the hospital's laboratory.

Construction

Grants totalling approximately $418,000 have been allocated to Nova Scotia hospitals as follows: to the new 213-bed Aberdeen Hospital, New Glasgow, $213,000; to St. Martha's Hospital, Antigonish, adding 111 beds, $111,000; to 10-bed Eastern Memorial Hospital, Canso, $5,500; to the new 64-bed hospital for mentally defective children at Brookside, $83,000; and toward the cost of converting a large residence in Musquodoboit into a 10-bed hospital, $5,400.

In Stanley, N.B., a grant of more than $7,000 was made toward the cost of converting a private home into a 13-bed hospital.

Hospitals in Ontario have been awarded grants totalling $89,500 to help meet building costs. These include: Hotel Dieu Hospital, St. Catharines, recently established 27-bed maternity hospital, $17,000; Saugeen Memorial Hospital, Southamption, $5,800; new 23-bed Red Cross hospital, Wiarton, $23,600; new 24-bed Red Cross hospital, Burk's Falls, $24,600; new 15-bed Red Cross hospital, Atikokan, $15,000; and the Red Cross hospital at Englehart, adding 14 beds, $3,200.

The sum of $202,500 has also been allotted to the Royal Ottawa Sanatorium towards the construction of a new 135-bed building, and that of $7,500 to the Brant Sanatorium to extend its capacity to provide five additional beds.

In Manitoba, the new 27-bed Minnedosa District Hospital benefits by a grant of about $28,000; the new 23-bed Morris District Hospital receives approximately $24,000; and a 9-bed Red Cross outpost hospital at Arborg will be granted $9,300.

Grants totalling $102,000 have been made to hospitals in Saskatchewan. Towards the cost of converting airforce huts into hospital space, Nokomis, adding 8 beds, received $8,000, and Waldheim, providing a new 9-bed hospital, $3,000. The Climax County Hospital, opened before its completion in 1947, has been granted $2,500 for this purpose. At Spalding, a new 9-bed hospital is being built, with $4,000 allocated towards construction costs, and at Oxbow, the present hospital, adding 10 more beds, will receive $10,000.

Further federal grants have been authorized in Saskatchewan to the following hospitals: Notre Dame Hospital, North Battleford, with a new 90-bed addition, $25,000; the new Neilburg Union Hospital, $9,000; 44-bed hospital at Kamsack, $34,000; the new Maryfield Memorial Union Hospital, to contain 7 beds, $3,300; and the Midale Union Hospital, converting an airforce hut into a 7-bed maternity hospital, $4,500.

Crippled Children

Federal funds have been earmarked to pay the salary of a physiotherapist for the orthopaedic wing of the General Hospital, St. John's, Newfoundland. She will give full-time attention to work in the children's ward. Additional rehabilitation equipment also is to be purchased with federal funds.

Mental Health

Money from the mental health grant has been set aside to pay the salaries of 11 new employees at the Hospital for Mental and Nervous Diseases in Newfoundland. The new members of the staff will include nine occupational therapists, five men and four women, a full-time instead of a part-time dentist, and a psychiatrist.

Federal funds, amounting to $8,800, have been allotted to buy equipment for the psychopathic unit of the Regina General Hospital and to increase the staff of Saskatchewan's mental health services. A psychiatrist will be added to the staff of the Saskatchewan Hospital in North Battleford; two social service workers are to be employed, one at the Saskatchewan Training School in Weyburn, and one in the newly established Saskatoon mental health clinic.

Personnel

Use of federal funds has been authorized to give an occupational therapist from the General Hospital, St. John's, Newfoundland, a two months' refresher course at the Shriners' Hospital, Montreal, and the Sick Children's Hospital, Toronto; and to give a technician a year's training at the Montreal Neurological Institute in the use of the electroencephalograph.

A technican from the Saskatchewan Hospital, North Battleford, will take a six-months course in electroencephalography in Toronto. Six persons have been awarded assistance for post-graduate training. Three will study hospital administration, one at Columbia University, two at the University of Toronto. A doctor from the Saskatoon cancer clinic will spend a year at the Bellevue Medical Centre in New York City studying internal medicine. The director of the provincial division of dental health will enrol at the University of Toronto for a year's course in dental public health, and the chief chemist from the provincial laboratories will take a year's special training in biochemistry at the University of Minnesota.

Public Health

More than $9,700 have been allotted to Newfoundland for a diagnostic survey to detect any existing cases of neurosyphilis. The federal grant will pay the costs of diagnostic examinations and the salaries of two nurses, a male attendant and a medical social worker, who will assist the present staff in carrying out the survey and arranging for treatment.

Federal funds have been set aside to pay the salaries of 11 additional persons for the provincial laboratory, Saint John, New Brunswick. Included are an assistant director, who will be a qualified physician to share the duties of the provincial pathologist; six laboratory technicians, two laboratory assistants; and two other assistants. The federal government has also provided money towards the salaries of two sanitarians, one for Westmorland, and one for Charlotte county.

A federal grant of $14,450 has been made to the nursing school of Hamilton College, McMaster University, so that they may increase their maximum number of students from 38 to 100. The grant will pay the costs of additional equipment and supplies for the nursing school and its laboratory and will help meet the salaries of a director, an assistant professor, two lecturers, special lecturers, clerical help, and laboratory assistants.

Research

A federal grant of $13,500 has been made to the Hamilton Medical Research Institute to meet the costs of providing their new isotope tracer laboratory with the highly specialized equipment needed in this type of research. The work of the laboratory will be closely related to the research in nuclear physics being done at McMaster University.

Tuberculosis

Use of federal health grants has been authorized to buy equipment for the examination and interpretation of chest x-ray films taken by the travelling diagnostic clinic, and for the purchase of surgical instruments for the Moncton Tuberculosis Hospital, New Brunswick.

The Royal Edward Laurentian Hospital has received a grant of $47,500, which will be used partly in the Montreal division and partly in the Laurentian division. In the Montreal division, a research laboratory and an eye, ear, nose, and throat section will be equipped and about $15,000 worth of x-ray apparatus will be added to the clinic. The remainder of the grant will be used to equip a laboratory and operating room and to buy fluoroscopic units for the sanatorium at St. Agathe des Monts. A federal grant of $19,300 will finance the plan of the Hotel Dieu de Montreal to establish a permanent tuberculosis clinic.

A federal grant of more than $53,000 has been approved for the dispensary operated by the Anti-Tuberculosis League of Quebec to enable it to expand its detection facilities. The funds have been earmarked for additional x-ray equipment and for the salaries of the additional personnel, including a full-time pathologist, a part-time medical director, four part-time doctors, and 11 nurses.

First Health Grant for Newfoundland

The first payment to Newfoundland under the federal government's national health program has just been made. Newfoundland is entitled to $19,779 to meet the expenses of a complete survey of its present health services and of its needs. A central health planning committee has been formed, consisting of the heads of the main divisions and the superintendents of the principal institutions operated by the Department of Public Health and Welfare. This committee will do work similar to that performed by committees in other provinces. It will study and make recommendations on all phases of public health and welfare. The survey is being undertaken under the direction of Dr. Leonard Miller, director of medical services for Newfoundland, assisted by specialists supplied by the federal department in Ottawa.

No pleasure is comparable to that of standing upon the vantage-ground of truth.—*Francis Bacon.*

25 Years Ago

October, 1924

The corner stone of the new clinic building of the Kingston General Hospital was laid on October 17 by the Honourable G. Howard Ferguson, Premier of Ontario.

Fifty medical men of the Ontario Neuropsychiatric Association met in annual convention at the Ontario Hospital, Whitby, on October 15th. Dr. J. M. Forster, superintendent of that hospital, was elected president of the Association.

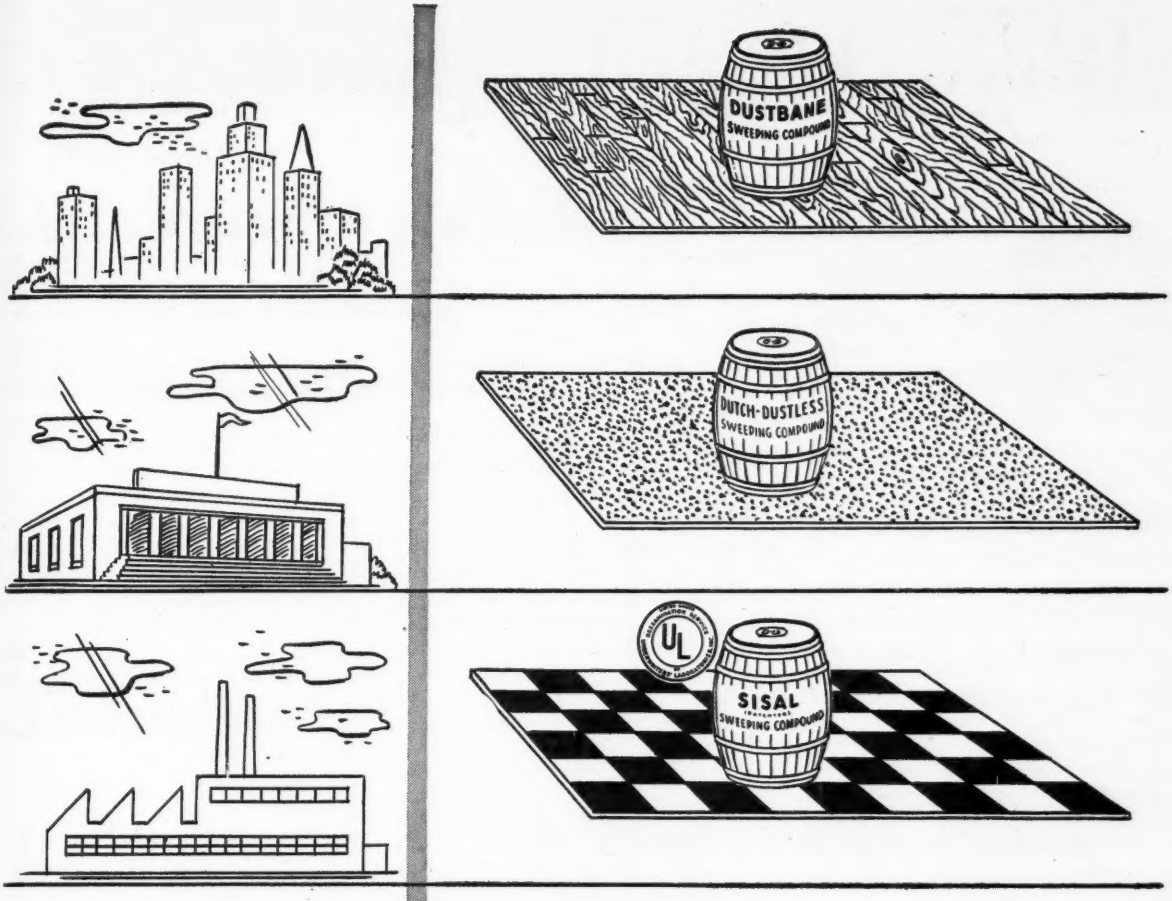
Miss Helen Mowat was elected president of the Ontario Society of Occupational Therapy at its convention which was held in Toronto on October 14th.

The new four-storey hospital at Camrose, Alberta, was opened this month. The fire proof hospital, which is operated by the Sisters of Providence, was built at a cost of approximately $100,000.

Dr. Campbell Palmer Howard was named professor of medicine at McGill University and senior physician to the Montreal General Hospital. These positions had once been held by his father, the late R. Palmer Howard, dean of the College of Medicine.

The Ontario Hospital Association held its first annual convention on October 2nd. William M. Gartshore of London was elected president and Dr. F. W. Routley was made honorary secretary-treasurer. The fiery Dr. Abraham Groves of Fergus castigated public wards as "an offense against decency". Dr. Frederick Mowbray of Hamilton and Miss G. Rowan of Grace Hospital (now part of the Toronto Western) praised the American College of Surgeons standardization program. From 50 to 60 per cent of Ontario hospitals had met the requirements. We note that our Editor, Dr. Agnew, demonstrated a new method of direct whole blood transfusion.

Dr. C. M. Henry was appointed head of the x-ray department of the Regina General Hospital. Dr. Henry was the first medical director of this department which, until this time, had been under the charge of a technician•



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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

For once I propose to deal with a subject which, while not immediately related to the work of hospitals, is of vital importance in all parts of the Commonwealth and Empire and has many points of concern to those who are engaged in the health services.

On Present Population Trends

Five years ago the Government appointed a Royal Commission "to examine the facts relating to the present population trends in Great Britain; to investigate the causes of those trends and to consider their probable consequences; to consider what measures, if any, should be taken in the national interest to influence the future trend of population". Their terms of reference confined them to an examination of the problem as it affected Great Britain, but it was impossible to do so without a realization that it existed in varying forms among other nations of the Commonwealth and that its right solution was essential to the welfare of the Commonwealth as a whole. The primary conclusion of the Royal Commission is that the population of this country must replace itself, which it has not been doing, though the statistics have improved since the war. Allied with this proposition is the policy, upon which there is general agreement among the nations of the Commonwealth, in favour of maintaining and strengthening the British element. The fact, shown in the survey made by the Commission, that this element seems likely to diminish is, as the Commission points out, a matter of vital concern to the whole Commonwealth. Accordingly, they recommend that the problem should be studied jointly by the Governments of Great Britain and the other countries. In fact, the increase or decrease of population lies at the root of nearly every problem with which they are confronted at the present time, particularly in the spheres of defence and economics.

In determining the causes of the "long persistence of a sub-replacement level", the Commission inevitably found themselves discussing the increased use of contraceptives as one of the main causes. They were led to the conclusion that "control by men and women over the numbers of their children is one of the first conditions of their own and the community's welfare and, in our view, mechanical and chemical methods of contraception have to be accepted as part of the modern means, however imperfect, by which it can be exercised". The Press fastened upon this passage to the detriment of full appreciation of the learning and reasoned arguments in the 230 pages of the report, in which the Commission had the assistance of three scientific committees dealing with statistics and economics and a biological and medical committee.

Before considering the relation of health services to the family, the Commission surveyed the services which are available to reduce the work and worries of mothers of young children. Perhaps the chief of these is the home help organized by the local authorities. At present, this service has scarcely advanced beyond the experimental stage though training and methodical management are doing much to improve it. "Sitters in" are given a place in their list of assistants, though generally they are friends who help each other as an act of goodwill to enable mothers to obtain a little relaxation. However, the Commission would have local authorities encourage voluntary schemes and "where necessary, should supplement voluntary effort in this field". The functions of day nurseries and nursery schools are now well established, but the Commission recommend that residential nurseries should be developed on an experimental basis for the care of children during the mother's confinement and to facilitate the mother having a holiday. The subject of holidays for all members of the family is a matter to which the Commission gave a good deal of attention. The bright summer just past has demonstrated that this is one of the marked changes in the national life; the number who have some form of holiday is now counted by millions instead of tens of thousands as it was not long before the war.

The new national health service has made an important contribution to family life by embracing wife and children who were not included in the previous insurance arrangements. The Commission see in this the prospect of strengthening the position of the family doctor—certainly a desideratum at the present time. Immediately related to the purpose of their inquiry is the question of infecundity and on this they recommend: "Facilities for investigation and treatment of infecundity should be provided as a regular part of the national health service, and research in this and allied problems should be promoted." At present, advice on contraception is normally limited to cases where it is necessary for the preservation of health, but the Commission would make it available through the national health service to all married persons.

The Commission naturally discuss at some length the improvements which are considered to be desirable in the maternity services, while recognizing that there has already been considerable improvement. In fact, the progress made during the years

(Concluded on page 104)

◂ Health Care Plans ▸

B.C. Hospital Insurance Announces New Premiums

As we go to press, representatives of the British Columbia Hospital Insurance Scheme report that hospital insurance premiums for 1950 will be set at a higher level with only two categories, instead of the present three.

The new premiums will be as follows: $21 per annum for single persons without dependents; and $33 per annum for one person with one dependent and for one person with more than one dependent.

Formerly the rates were $15 for single persons with no dependents; $24 for one person with one dependent; and $30 for one person with more than one dependent.

* * * *

Federal Employees Now Enrolling in Blue Cross

Federal civil servants are now permitted to have Blue Cross protection on a payroll deduction basis. This was made possible through the introduction of Treasury Board No. T-344970 B. The Blue Cross plans and the federal government have been negotiating on this point for some months. The arrangement opens up a potential of 160,000 subscribers plus members of their families.

Commenting on this development, *Blue Horizons,* which is published by the Quebec plan, states: "When all civil servants have been given an opportunity to enrol during the big August 29—September 23 opening period, the Canadian government will have become the largest employer to place Blue Cross benefits at the disposal of employees and their families on a payroll deduction basis.

"This adds tremendously to the importance of Blue Cross in Canada, but better still, it adds considerably to the peace of mind and welfare of all Canadian citizens in general. It is indeed an occasion to be proud of."

* * * *

Les Employés Fédéraux Peuvent Enrôler dans la Croix Bleue

Les employés du service civil fédéral peuvent maintenant avoir la protection de la Croix Bleue sur une base de déduction sur le salaire. Le passage par le gouvernement fédéral de la minute T-344970 B. a rendu ceci possible. Ce nouveau groupe aura un maximum possible de 160,000 souscripteurs sans compter les membres de leurs familles.

Sur ce développement, *Horizons Bleus,* publié par le plan dans la province de Québec, dit: "Lorsque tous les fonctionnaires auront eu l'opportunité de s'inscrire au cours de la grande période d'ouverture—laquelle durera du 29 août au 23 septembre—le Gouvernement canadien sera l'employeur ayant le plus grand nombre d'employés au Canada qui aura mis les bénéfices de la Croix Bleue à la disposition de son personnel sur une base de déduction sur le salaire.

"L'ouverture du Groupe 20,000 augmente considérablement l'importance de la Croix Bleue au Canada; mais ce qui est plus important encore, elle augmentera surtout le bien-être et la sécurité de tous les Canadiens en général."

* * * *

Anywhere in the World

Recent reports show that the Blue Cross Plan for Hospital Care in Ontario has paid hospital bills in Johannesburg, South Africa; Oslo, Norway; Copenhagen, Denmark; and in London, England.

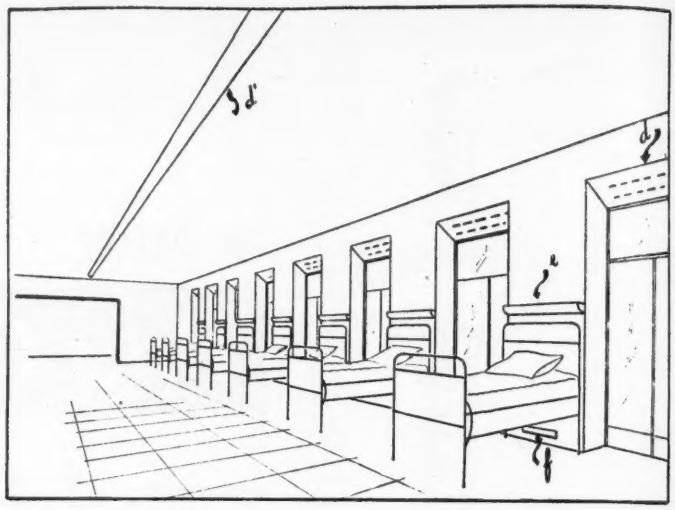
Brine Bath Cures in France Covered by Health Insurance

A doctor once said, "Too many holidays are spent uselessly in places chosen at random, without medical advice and with results which are often more harmful than favourable". Someone may go to the seaside when the mountains would suit better; another may decide to take a high altitude cure when, on the contrary, he would benefit from a long stay at sea-level.

Tourists, sick people, and even doctors are too often lacking in precise information concerning bathing and health resorts. To remedy this lack, the Federation Thermale et Climatique de France recently organized in Paris "thermal days", or information days. Here general practitioners, students, and doctors, specializing in spa cures attend lectures by eminent medical men on different illnesses treated in French resorts and on the specialization of these resorts as the result of scientific research.

In France, those benefiting from health insurance are given water cures free, the only country in the world in which health insurance offers such advantages to the poor.—*French Information Service, Ottawa.*

The Honourable D. C. Abbott, Minister of Finance (seated), and Mr. E. Millican, Blue Cross Commissioner for Canada, discuss enrolment of federal employees in the Blue Cross.



Eclairage par Fluorescence à appliquer dans les hôpitaux

L'ECLAIRAGE général des Chambres Communes peut être réalisé de deux façons différentes. Le premier, et le plus intéressant pour les hôpitaux à notre avis, consiste à placer au-dessus de l'imposte de la fenêtre un réflecteur du type GT.

Le *détail d* représente une coupe à l'endroit de l'encastrement du réflecteur. Devant le réflecteur est prévu une dalle en verre sablé.

Pour des installations existantes, il n'est très souvent plus possible de prévoir l'encastrement au-dessus de l'imposte de la fenêtre. Nous pensons que l'avantage du procédé est tel que l'on peut sacrifier une partie de l'imposte pour l'installation du réflecteur.

Comme la disposition des lits est telle que les malades ne sont pas gênés par la lumière diurne et qu'avec ce procédé la lumière artificielle vient du même côté, les malades sont automatiquement mis à l'abri de l'éblouissement par l'éclairage artificiel. Dans le cas où l'application décrite précédemment n'est pas possible, il peut être fait appel à l'éclairage par le centre de la pièce. *(fig. 1 lettre d*[1]*)*

Il consiste à placer une ligne ininterrompue de lampes TL. L'on peut alors prévoir l'habillage ou l'encastrement comme dans l'éclairage de circulation des couloirs.

L'éclairage individuel est composé d'une corniche *(détail e)* dans laquelle est prévue une fente afin de diriger une partie de la lumière directe vers le malade, l'angle étant calculé de telle façon que les yeux du malade ne puissent rencontrer le tube, ceci bien entendu dans le cas où la corniche est en métal opaque. Si la corniche est en matière translucide tel que du perspex par exemple, il n'est pas utile de prévoir cette fente.

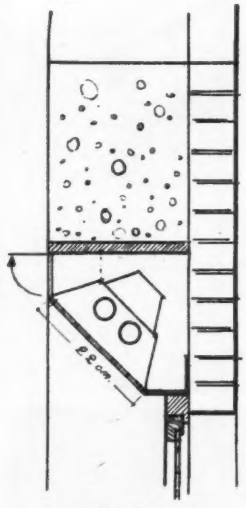
La corniche est équipée d'un support standard du type PA muni d'une lampe TL 25 ou 40 W.

Pour l'éclairage de nuit on peut prévoir dans le mur un renfoncement comme indiqué à la coupe *(détail f)*.

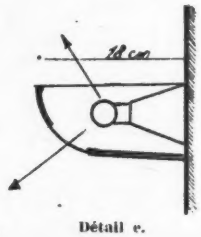
Dans le haut du renfoncement est prévu un support standard équipé d'une lampe TL 20 W., la lampe étant dissimulée à la vue directe au moyen d'une cache en métal ou en bois approprié. Ainsi, un filet de lumière non-éblouissante est projeté dans la salle et permet la circulation du personnel de nuit sans troubler le repos des malades.

Le même principe que celui décrit pour l'éclairage des chambres communes est évidemment applicable aux chambres individuelles. Les *détails d, e,* et *f* sont applicables et conseillés.

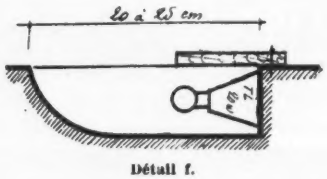
Extrait de "L'Hôpital", organe officiel de l'Association Belge des Hôpitaux, décembre, 1948.



Détail d.



Détail e.



Détail f.

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Provincial Notes

British Columbia

KELOWNA. Plans are under way for the construction of a new wing for the Kelowna General Hospital. The wing will provide an additional 55 to 60 beds, 2 major operating rooms, two maternity rooms, and other facilities. The estimated cost is $400,000.

* * * *

NEW WESTMINSTER. When fire swept through the Hollywood Sanatorium, which caters mainly to persons suffering from extreme alcoholism, the seventy patients were evacuated from the building without a sign of disorder or panic. Stretchers and doctors were rushed from Vancouver but not one injury was reported.

* * * *

VANCOUVER. In its 1949 Annual Report Competition, the magazine *Hospital Management* has awarded honourable mention to the Children's Hospital of Vancouver. An award certificate was presented by the Editor to a representative of the hospital during the A.H.A. Convention in Cleveland last month.

Alberta

ATHABASKA. On January 1st, a number of townships will be detached from Athabasca Municipal Hospital District No. 13. This move will no doubt affect the proposed new $250,000 hospital project, for which plans have been drawn up. It is expected that new plans on a more modified scale will now be submitted by the architects.

* * * *

RED DEER. Rapid progress is being made in the conversion of a former army hut to a nurses' residence at the Red Deer Municipal Hospital. The building will contain a large sitting room, a lounge, a small kitchen, and single and double rooms.

Saskatchewan

NOKOMIS. Miss Tillie Webber, Reg.N., who has been matron of Nokomis Union Hospital for the past five and a half years, retired last month. She is succeeded by Miss Edith Todd, Reg.N., formerly of Port Arthur and for the past three years matron of Little Bow Municipal Hospital at Tabor, Alta.

* * * *

REGINA. At the Regina Grey Nuns' Hospital a completely new and modern nursery is being planned. It will include an incubator nursery and also a special department in the children's ward for incubators. The maternity division will occupy the fourth floor of the hospital's new wing.

* * * *

SASKATOON. The Hospital Board of the Saskatoon City Hospital has approved a recommendation to replace the centre block of the hospital, which is not fire-proof, with a new 4-storey structure which will house 75 patients. It will also contain laboratories, kitchens, waiting rooms, doctors' rooms, nurses' rooms, operating rooms, administrative offices, and a dispensary. The cost will be approximately $500,000.

Manitoba

WHITEMOUTH. The Manitoba Pool Elevators have presented a $3,000 cheque to the Whitemouth District Hospital Board for its 10-bed hospital. The cheque was the 21st $3,000 donation from the Manitoba Pool Elevators Hospital Memorial Fund to Manitoba hospitals. The first sod for the Whitemouth Hospital was turned on July 30 and the hospital will be completed in the spring of 1950.

Ontario

BELLEVILLE. The Board of Governors of Belleville General Hospital has approved the appointment of Miss Dorothy Potts as director of nursing, according to an announcement by the superintendent, Mr. H. W. Wakefield. Miss Potts, who came originally from the Moose Jaw General Hospital, was graduated from Columbia with the degree of bachelor of science in nursing education and has recently been on the staff of the Toronto General Hospital.

* * * *

EXETER. Preliminary plans have been drawn up for a 25-bed hospital. With an estimated minimum cost of $200,000 the hospital will include emergency treatment rooms, an x-ray room and laboratory, nurses and staff quarters, facilities for minor surgery, and a nursery with 10 cubicles. The building will be two storeys high and of T-shaped construction.

* * * *

LONDON. Work on the new 200-bed addition to Victoria Hospital is expected to get under way next spring. The new wing will house the cancer clinic operated by the Ontario Cancer Treatment and Research Foundation and supply accommodation for its patients.

* * * *

OTTAWA. An addition is under construction at the Royal Ottawa Sanatorium, which will provide beds for 135 more patients. The new building will also contain an x-ray department, administrative offices, limited quarters for resident physicians, laboratories, and a dispensary. Construction is expected to be completed about September, 1950.

* * * *

PORT PERRY. The Port Perry Hospital Board has purchased for $360 a 55-room building situated at Ajax. They plan to transport the building to Port Perry and to convert this former residence for women war workers into a 60-bed hospital. It is expected to be ready for occupancy by next spring.

* * * *

SARNIA. A citizens' committee is being organized to act with the

(Concluded on page 104)

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Your Pharmicist

(Continued from page 38)

oven is used for powders, oils and greases.

Hypo Needles

Some 400-600 hypo needles are cleaned each day for use on the various trays and are placed in single and double hour-glass holders for sterilization. The chief engineer has been working on a semi-automatic apparatus which will handle 20 needles at a time. This apparatus, now almost perfected, will save considerable time since each needle is handled five times, making a minimum of 2000 operations per diem to process needles alone. Needles are collected, on return from the wards, in a solution of hydrogen peroxide to leech out organic detritus and to act on pyrogenic material; they are then hubbed, rinsed out by pressure with hot tap water, hot distilled water, ether or alcohol, and finally air. All supplies are subjected to the best known methods of sterilization and kept in sterile storage for immediate issue at all times. The flow plan of the department is such that unsterile and sterile supplies cannot be mixed. Needles requiring sharpening are sent to the engineering department.

Much time is saved by having rubber gloves processed in part in the laundry department. They are sent there to be washed in the automatic washers and dried in the tumblers, inspected for leaks after being inflated with a jet of compressed air, and patched if necessary; they are returned to the central supply room for wrapping and sterilizing. Biosorb is used for powdering in place of talc. In addition to saving time, the laundry processing provides a glove of finer texture than does hand washing.

Ward supplies are issued upon requisition. Routine supplies are requested twice daily and are delivered by the central supply room staff. Emergency supplies or those required at other times are issued upon special requisition. Approximately 10,000 sterile and non-sterile items are issued monthly from this department.

Intravenous Solutions

During the first year of operation, a saving of over $7,000 has been realized over what would have been the cost if purchased from a commercial firm. Moreover, we are able also to prepare many solutions that are not available commercially. This figure does not take into consideration the preparation and use of over 5,000 litres of sterile pour-o-vac solutions for use as wet dressings, irrigations, et cetera, which represents a further considerable saving and convenience.

Equipment in this room consists of an automatic pressure washer for flasks and tubing, two 10-gallon per hour Castle reflux stills (single), rinsing apparatus, filling and mixing burettes, a Fenwall Unit A and B, and an adequate supply of flasks, bushings, et cetera, to maintain sufficient solutions for stock. It is necessary to prepare solutions on an average of one working day for two people every ten days. A rigid cleaning program is carried out and distilled water is not used unless it shows less than 2 p.p.m. electrolytic impurities. Occasional pyrogen tests U.S.P. are carried out with rabbits, and the pathology department conducts spot sterility checks, selecting bottles at random from different lots. The Fenwal system has been found convenient and easy to use, giving rise to no problems in reactions or otherwise since its inception.

Pharmaceutical Laboratory and Dispensing

In this department the day begins with the filling of ward baskets with routine supplies. There are twelve baskets to be filled and the task occupies about one and a half hours each morning. Any special medications sent up with the baskets are charged to the patient. Narcotic supplies are replenished and issued to the floors when the nurse calls and signs for them. A control sheet is issued with each vial of tablets or solution and must be returned with the drug properly accounted for before new supplies are issued. The sheet, with any remarks entered by the pharmacist as to discrepancies, et cetera, is then sent to the director of nursing and. when signed by her, is returned to the pharmacy for filling. The remainder of the day is spent in manufacturing, filling prescriptions and special orders, and filling ward stock bottles. All routine medications, such as sedatives, liquid and tablet laxatives, germicidal solutions, aspirin and aspirin compounds, are stocked on the wards and are not charged to the patient. These supplies are kept pre-packaged, saving considerable time in the busiest part of the morning when full bottles are exchanged for empties.

A supply of all ordinary equipment, such as bunsen burners, balances, and a colloid mill for emulsions and milk of magnesia, is kept for the manufacturing of non-sterile products. A special emulsion is preferred to alcohol for back lotion.

Penicillin and streptomycin are issued to the floors diluted ready for use in any concentration desired. A

(Concluded on page 96)

Saskatoon City Hospital Appoints Superintendent

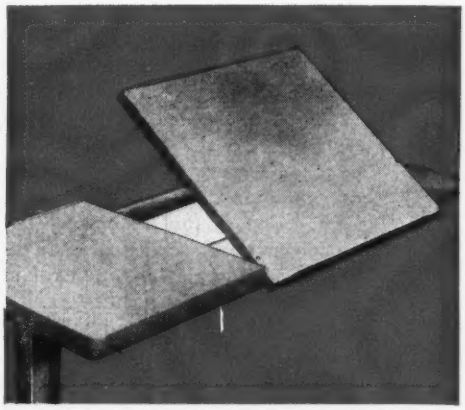
Mr. L. T. Muirhead has been appointed general superintendent of the Saskatoon City Hospital. Previous to his appointment, Mr. Muirhead was acting director of the hospital accounting and administration division and chairman of the hospital rates board with the Saskatchewan Hospital Services Planning Commission. He also served as a supervisor of auditing in several provincial departments, acted as corporation assessor with the income tax division at Regina, and directed auditing of Canadian army expenditures for the federal government during the second world war.

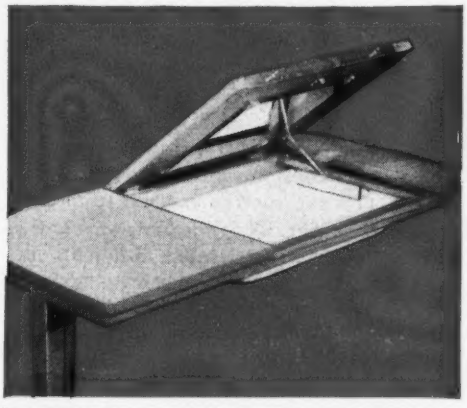
In his new position, Mr. Muirhead succeeds Alexander Esson, who died in April of this year.•

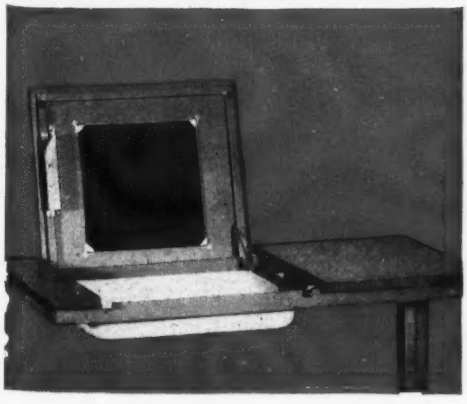
New...Convenient

Single Pedestal Table

adjustable to bed or chair







● This new type of table is ideal for both convalescing and bed patients. It can be used from right or left side of bed or chair and is easily operated by nurse and patient.

Light pressure release lever provides fifteen points of adjustment one inch apart. Mechanism for elevating or lowering table is counterbalanced. Easily removed porcelain enamel tray provides space for patient's toilet articles and other necessities. Table top is Laminated Plastic in crash linen finish—wear and stain resistant.

Metal gliders are standard at post end of table with 2" rubber-tired casters at front. Frame available in any of Simmons standard finishes. Approximate dimensions:

Top overall	14" x 32"
Tilting section	14" x 16"
Mirror	9" x 9"
Tray	9" x 15"
Minimum adjustment height	29½"
Maximum adjustment height	44½"
Base	16" x 25½"

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The Patient and His Friends

(Continued from page 32)

the obvious application to our patients. Executives in industry demonstrated the value of applying psychological knowledge to personnel administration and we have gradually accepted and applied the principles to our own staffs.

But the principles revealed in the study of human behaviour operate not between certain individuals or groups of individuals but between two or more people wherever they meet. Our every contact is a form of social interaction, one of aggression, competition, co-operation, or sympathy, and there is no place in a hospital for any form of interaction that is not co-operative and sympathetic. Said Professer Donald Johnson: "In contrast to sympathy, which is a passive sharing of emotional experiences, co-operation involves sharing goals and taking active steps toward those goals."

Control of Visitors

The usual active steps taken, not so much to enlist co-operation as to control visitors, include a card system whereby a receptionist permits two people only to visit a patient at one time; the control and direction of traffic by doormen; or the attempt of a depleted nursing staff to check the flow of people into the wards. Control is as necessary in the hospital as on the street, but the methods of control may result in an antagonism that is transmitted in one way or another to the patient.

Professor Johnson's statement that a person feels more or less loyal to his group (especially when his own group, the in-group, is at odds with some out-group) has significance for us. So easily we may become the out-group, if by any word or action the relatives feel that we are not sufficiently concerned about the patient, the centre of the in-group.

Staff Instruction

Our first active step should be to examine critically the instruction that is being given to every member of the staff in a gracious approach to visitors. The soft answer that turns away wrath, the quiet, brief explanation that eases the distressed mind, should become so habitual that they will be less time consuming than the abrupt replies which elicit a number of questions.

I was very impressed recently by the response of members of a hospital auxiliary to a discussion of everyday hospital problems, and somewhat embarrassed by the statement that the members had always been given the impression that they were expected to remain at a discreet distance. In speaking of the failure of a hospital staff to make any explanation whatever regarding her mother's condition or care, one woman said, quietly but with some bitterness: "We are not morons, you know; a simple explanation would ease my mind, would give me confidence, and prevent me from asking unnecessary questions." Her mother was taken to the hospital with a fractured femur, she was placed in bed, and no apparent treatment given. The doctor examined her and left without seeing the daughter. At no time did anyone explain that the patient was first being treated for shock and the leg would be set the following day. The daughter left the hospital antagonized by the apparent lack of treatment and determined to return as soon as possible to assure herself that her mother was receiving reasonable care. To give instruction repeatedly and, what is more important, to see that it is carried out takes time but would prevent just such an attitude.

A harassed information clerk is too often frustrated in her attempt to answer enquiries satisfactorily, because the condition sheet gives no real information. By more completely filling out condition sheets and giving descriptive information such as: "The patient is taking more nourishment", or "He was up yesterday", we may counteract the dissatisfaction that the reply "His condition is fair" will elicit.

As hospitals are expanded and sun-porches are being used for ambulatory patients, the situation will be much improved. Patients who are very ill will not be exposed to the disturbance caused by the proximity of other patients' visitors. Wherever better accommodation is provided for visitors, the

(Concluded on page 112)

Hands Across the Fairway After Playoff

Dr. Andrew R. McGee and his son, Don, left and right centre, broke a tie to win the championship at the Ontario Golf Association's annual Parent and Child Tournament held last month. Formerly head of the department of medicine at the Toronto East General and Orthopaedic Hospital, Dr. McGee is now on the consulting staff of that hospital.

Also on the staff of the Toronto East General, Dr. W. C. Givens, with his son, came in fourth in the championship finals. The father and daughter low net was won by Dr. R. E. Davidson and his daughter, Muriel.

A leaflet on Anacap Surgical Silk on spools is now available on request.

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A non-capillary silk of exceptional tensile strength, outstanding for many years as a specialty suture in combination with D&G Atraumatic® needles, Anacap Black Braided Silk is now available on spools, unsterilized, in lengths of 25 and 100 yards and in range of sizes from 6-0 to 5.

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Non-capillary under all conditions to which sutures are exposed, D&G Anacap Silk is of such high tensile strength that it may be used in finest sizes without danger of breaking. It is free from stiffening lacquers or traumatizing substances.

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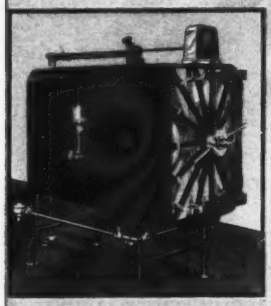

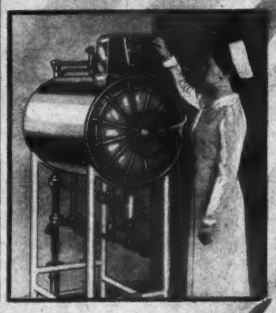

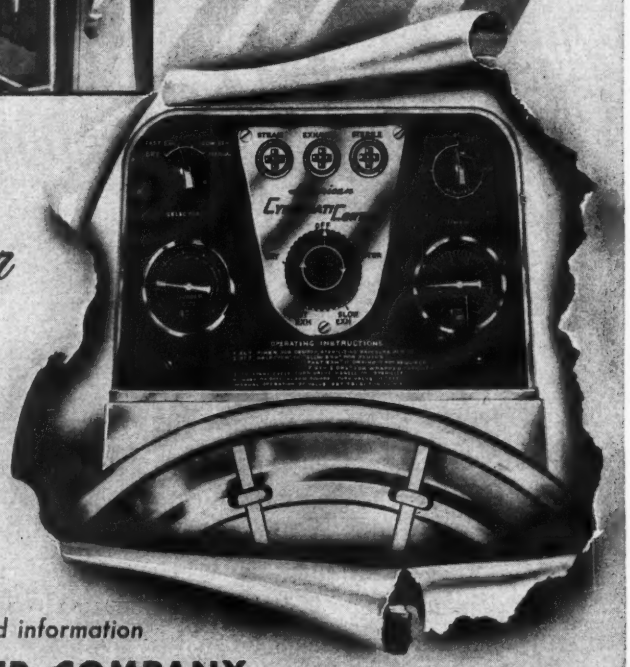

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How to Reduce China Breakage

WITH good management, good dishwashing equipment and good dishes, the problem of breakage can be cut to a minimum. The first step is to buy the best and most durable dishes you can find. The dishes must stand hard wear and occasional rough handling with a minimum of chipping, cracking and breaking.

Much tableware today is vitrified all the way through, so that if a chip escapes the eye of the dishwashing supervisor, and the piece continues in use, it is still sanitary. Vitrified means that the ware is non-porous and non-absorptive. It cannot be a carrier of germs of any kind because of chipping. Chipped and cracked pieces should be weeded out as soon as they are spotted. A daily inspection schedule may prove helpful.

The second step is to handle china intelligently. The loss by breakage may begin in the dining room, but the greatest breakage occurs after the dishes have become soiled. It is at the soiled dish table that the greatest percentage of breakage usually occurs. Have it large enough to accommodate as many dishes as you use at your peak service period. If necessary, reshift your personnel so that an extra man may be available at the soiled dish table during rush hours to empty the boxes and stack the dishes.

The method of stacking is important. Care should be taken that the heavier dishes are not placed on those of lighter weight. Plates, cups and saucers should be placed in separate stacks. Glassware should be kept separate from china, and silver should be apart from both. The stacks should be confined to a reasonable height.

If your soiled dish table is not adequate, and if you have not enough space in which to install a larger one, install additional shelves as close to the soiled dish table as possible—or build shelves over or under your existing table.

Your dishwashing equipment should be the best and most modern that you can afford. Not only does this cut down the breakage, it makes living up to present-day sanitation requirements much easier. One part of a modern dishwashing set-up consists of a fountain of warm running water, mixed with detergents, which is used to rinse each dish free of food particles. The elimination of hand scraping cuts down breakage.

Never use abrasive on china. If food sticks to the ware, remove it with special bleaches or china dips and save the surface of the glaze. Abrasives will scratch and wear down the smooth surface of any plate.

In the modern dishwashing pantry the man who operates the pre-rinsing machine stacks the rinsed dishes in the washing racks. In stacking dishes there should be no crowding or overloading. Weight creates a hazard. Load the racks evenly, one row of dishes against each—and all of the same size. The loaded racks then go to the dishwashing machine.

In all good dishwashing machines the temperatures are thermostatically controlled. In the first compartment the temperature of the wash water is kept at approximately 130 degrees. It is mixed with a soap solution that feeds into it automatically in the correct amounts. Water that is too hot will cook the food particles on the plate; water that is too cool will not do a proper job of cleaning.

The dishes go through the washing process on a conveyor belt. From the washing compartment they move into the rinsing tank, where the temperature of the clear water is kept at from 140 to 160 degrees.

The last in the three-compartment type of dishwashing machine is the sterilizer. Here the dishes are sprayed with scalding water at about 180 degrees. Good china will withstand terriffic hot and cold shocks. But in a modern machine no dishes are subjected to such treatment because the temperature is raised gradually.

Special handling and good equipment are also necessary in the stacking and storing of dishes after washing. Cup trays in which each cup is placed in an individual compartment, should be used. This eliminates much of the breakage of cup handles.

If the manager will consider the dishwashing pantry as one of the places where breakage costs may be reduced sharply he will see the importance of training personnel properly. Dignify the job of dishwashing by calling the man you hire for the job a dish machine operator. Once you realize that a good man on this job will cut your cost substantially, an increase in his salary or a bonus in return for his careful handling of dishes will be an expense repaid many times over in the reduction of china losses.

If you will follow the few simple rules above you will find that good china will withstand the hazards of breakage with flying colours.

Wilbert A. Betz in "Restaurant Management", Hospital Abstract Service.

Pan American Sanitary Bureau Forms Hospital Section

The Pan American Sanitary Bureau is establishing a new section to deal with problems of hospital construction and administration and to extend the sponsorship of the Bureau to the Inter-American Hospital Association.

The Hospital Section, with Mr. Felix Lamela as Chief, is sponsoring the Third Inter-American Institute for Hospital Administrators to be held in Rio de Janeiro, Brazil, April, 1950. The Brazilian Government has appropriated $15,000 to cover part of the cost of organization and a prominent group of educators will form the faculty. The academic program will be conducted simultaneously in Portuguese, Spanish, and English with the use of the international translator.

In the capacity of a technical consulting office, this new section will deal with requests of the Ministries of Health of the participating governments on problems of surveying, planning, equipping, and administration and management of hospitals.

The Bureau is also the Regional Office of the World Health Organization and has its central offices at 2001 Connecticut Ave., N.W., Washington, D.C.

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The Human Side of the Hospital

HOSPITALS, like business houses, find themselves in a new era in which employees refuse to be treated as menials or as spiritless automatons. Instead, they assert themselves as human beings, with the rights and requirements inherent in men and women. Since this era is here, and here to stay, hospitals must accept it, adapt themselves to it, and utilize its opportunities. The means of doing so have already been explored by commerce and industry. . . . Progressive businesses have met the challenge by establishing professional personnel departments. These, in turn, have developed new procedures of hiring, training, dealing with grievances, and elevating morale. . . .

Let us now suppose that a hospital has determined to apply a similar solution to its personnel problems. That decision must be made by the trustees after consultation with administrative and medical staffs, all of whom must be ready to stand behind it. The next step is to engage a personnel director or—if the hospital is too small to hire one—to borrow the services of an expert from local business. . . .

The administrator faced by over-all problems must be prepared to see his personnel director start with seemingly trivial things. Were I such a man, I should probably begin by fitting out an attractive office in which applicants for jobs could be received and carefully interviewed. While waiting for this office to be built or decorated, I should certainly get a competent stylist to redesign the uniforms of lay employees. Almost without exception, these uniforms are now unattractive and ill-fitting. . . . It is hard to believe that any person so attired can feel pride in himself or his work. . . .

Careful Tests Necessary

The next task of the personnel director is to improve hiring practices. These now range from half-hearted attempts at thoroughness to uncritical acceptance of almost anyone who comes to ask for a job. As a result many hospitals actually find themselves with lay staffs that include criminals, mental and moral misfits, and people who lack ability to follow directions for performing even the simplest jobs. This can be prevented only by careful interviews and checkups, followed by tests to determine interests and aptitudes . . .

It is not enough, however, to hire good people; the hospital must also turn them into good and efficient workers. This can be done by training, though not the kind that allows a new employee to watch an old one for a day and then tells him to go do as well. Modern training begins with orientation, which gives the employee an understanding of his place in the hospital, shows him the purpose and the value of his work, and explains rules and policies by which he will be affected. This must be followed by specialized job training, which is just as necessary for cleaning women as it is for orderlies and cooks.

These are not small tasks, yet modern training goes further. It shows the employee how to work effectively, so that he wastes a minimum of effort and obtains best possible results. At the same time, training proves to him that he is respected and appreciated and convinces him that his services are valued by the hospital. . . .

The final task for the personnel director is to develop a new feeling of partnership among the lay and professional staffs. Interviews show that dissatisfaction and resentment are now widespread, especially among lay workers who resent the superior attitudes of the doctors, nurses, laboratory technicians, and other professionals. To a lesser but still serious extent, nurses feel resentment towards doctors, regarding many of them as autocrats who give the nurse little credit for knowledge, skill, or judgment, in dealing with patients. Physicians and surgeons, in turn, resent what to them is the surly attitude of some nurses, and are forthright in their condemnation of inefficient and indifferent lay employees. Aware of these seething currents of ill will, the administrator too often falls back upon iron discipline in an effort to keep things under control.

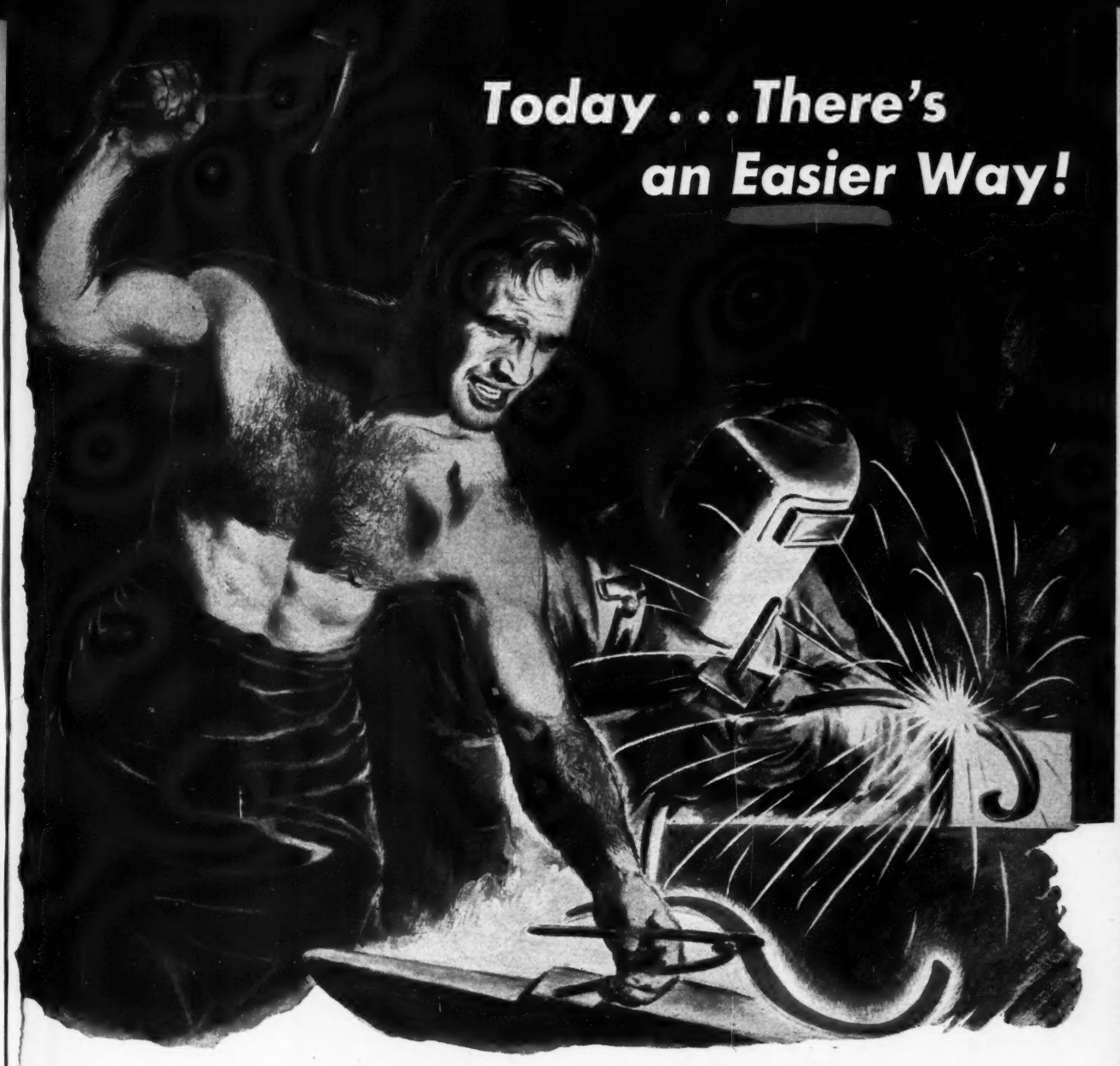
Discipline prevents explosion; it remedies no evils and frequently aggravates them. To achieve a remedy, those who manage our hospitals must scrap the outworn caste system and deal with all staff members as self respecting men and women. . . . The modern nurse, the product of years of training, is a skilled and responsible person who is ready, and should be allowed, to act as the doctor's junior partner. The same is true of the technician, whose tests and reports form the basis of much surgical and medical work.

A greater gap exists between the professional and lay personnel. With few exceptions, today's lay employees are not exceptionally able people, nor do they possess technical skills developed by years of education. Still, they are people; they do have abilities, and those abilities can be improved by opportunity and training. Surveys indicate, moreover, that more and more of the hospital's technical work can and probably must be turned over to competent lay personnel, just as much work once done by student nurses is now handled by orderlies and maids. The surest way to achieve this result is to raise the status of lay employees, at the same time hiring workers who can meet increased responsibilities. . . .

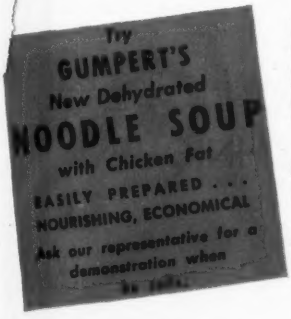
Hospital Is a Business

We next consider the question of costs. Although there still are a few skeptics, the record proves that modern personnel methods, including careful selection of employees and thorough training, reduce cost per unit of product, which is the business equivalent of the hospital's patient day. There is no reason to believe that these same methods, supported by labour-saving equipment, will be less successful in hospitals.

Extracts adapted from an article, under the same title, by Robert Wood Johnson, in "Modern Hospital", Feb. 1949.



. . . to Stretch the Hospital Food Budget



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O.H.A. to Celebrate 25th Anniversary

At its annual convention, to be held in the Royal York Hotel, Toronto, Oct. 31 to Nov. 2, the Ontario Hospital Association will celebrate its 25th anniversary. As we go to press a preliminary program has come to hand which promises exceptionally interesting sessions. The meeting will be officially opened by the Honourable, the Lieutenant-Governor of Ontario, with greetings from the Minister of Health (Ontario) and His Worship the Mayor of Toronto.

At a special luncheon on the first day, the guest speaker will be Dr. G. D. W. Cameron, Deputy Minister of National Health. Other guest speakers, during the course of the program, will be Dr. Henry Farish, of Southampton, N.Y.; Dr. G. E. Wride, D.N.H.&W., Ottawa; Dr. A. D. Kelly, assistant secretary of the Canadian Medical Association; Charles F. Neergaard, architect, New York City; Dr. Sydney Smith, President, University of Toronto; Everett W. Jones, technical adviser, *Modern Hospital*, Chicago, and Dr. Malcolm T. MacEachern of Chicago.

The program will cover a wide variety of subjects with emphasis on health insurance and construction. There will be seven sectional meetings, a round table conference, at least two films, and a visit to the new wing of St. Joseph's Hospital. After the banquet on Tuesday evening, delegates will again enjoy a floor show arranged by the exhibitors.

C.S.L.T. President Makes Field Trip

Directors of laboratories and laboratory technicians are again reminded that next month the President of the Canadian Society of Laboratory Technologists, Miss Ileen Kemp, will begin a field trip across Western Canada, visiting most of the larger centres. The main purpose of such a trip will be to enlarge the membership of the Society by personal contact with groups of as many registered and unregistered technicians as possible. It is also hoped that such a tour will prove to be a co-ordinating influence between the provinces and the Dominion Executive. In this venture the C.S.L.T. urges the wholehearted support of its membership at large. For further information see *The Canadian Hospital*, September, p. 58.

Standardized Curriculum Planned by C.S.R.T.

At the annual convention of the Canadian Society of Radiological Technicians, the President, Mr. P. E. Hunt stressed the fact that the most important matter facing the Society was the setting up of properly organized schools of training. At the present time, it was pointed out, there are very few centres where adequate training can be given and an effort will be made to rectify this by providing courses of instruction with a standardized curriculum for the whole country. In order that this may be accomplished, the Society and hospital administrative staffs will require the close co-operation of the Canadian Medical Association and the Canadian Association of Radiologists.

Treatment Regulations in Care of Veterans

IN view of the fact that the most active period of treatment of ex-servicemen is over, the Department of Veterans' Affairs has issued a reminder to all concerned of certain important points in the *Treatment Regulations* concerning veterans.

Most veterans now eligible for treatment are either pensioners (eligible for pensionable disabilities only, Class 1) or War Veterans Allowance recipients (eligible for *essential* treatment for any condition, Class 5B). Both of these classes may receive casual and emergency treatment at home or at a doctor's office on approval by the District Medical authorities but investigation, extensive treatment, or hospitalization, is to be carried out in D.V.A. institutions unless serious emergency exists and local facilities must be used. There is, also, a group who have meritorious service and whose income is under certain economic ceilings, who may qualify for treatment in a D.V.A. hospital where the prospective expenses are very serious economically (Class 5A). In addition, there is a diminishing group of students who, while drawing D.V.A. training allowances, may receive free treatment (Class 3).

In all cases, where the doctor has not received previous authority from the department, he should immediately seek such authority from the nearest D.V.A. district office. For the Department to consider accepting responsibility from the commence- of treatment, such applications must be received within thirty days of that time.

Doctors are asked to use Form D.V.A. 525 (triple carbon copy) and follow instructions inside the cover of the book. Accounts should be in early and especially within thirty days of the beginning of treatment.

Form D.V.A. TS 29 (Notification of Admission of a Veteran) and Form D.V.A. TS 30 (Notification of Discharge of a Veteran from Hospital other than Departmental) are furnished in pads of 50 and are available in French (D.V.A. TS 29 and 30 Fr.). For ease of recognition, notifications of admission are printed on green paper, notifications of discharge on white. These forms are for use in other than Departmental Institutions and Departmental District Medical officials will be responsible for their distribution to the various hospitals within their disticts. The forms carry no authority for treatment, but serve simply as a notification to the district office of admission or discharge of a veteran. Sufficient information has been included to enable location of the veteran's file in order that eligibity may be determined. The importance of promptly completing these forms, both from the standpoint of the veteran and the treating authorities is obvious.

The Auxiliaries

Women's Aids Flourish in B.C.

"It has been interesting to see that the effect, so far, of the Hospital Insurance Act (British Columbia) has been to rouse a greater public interest in the hospital auxiliary work. At first we had to do a lot of public relations work to clear up misunderstandings of the Act but have been well repaid. We feel that the work we have done in that line alone has justified the use of a Provincial body."—*Mrs. G. E. Masters, Sec.-Treas., Women's Aids to B.C. Hospitals.*

* * * *

Misericordia Aid, Edmonton, Serves Hospital Well

One of the younger Alberta aids, the Women's Auxiliary to the Misericordia Hospital, Edmonton, has a fine record. With a membership of only forty-three members, the auxiliary has made generous donations to the hospital, particularly to the paediatric department, and has supplied several oxygen tents and an ophthalmoscopic set.

* * * *

Ladies Form Hospital Guild

The ladies of the River Hills district met recently to organize a hospital guild to work jointly with guilds in adjoining communities in serving the hospital to be built at Whitemouth, Manitoba. The president is Mrs. A. Besskau and guild members will meet monthly.

* * * *

Gift Received by St. Thomas Women's Aid

Last month the Mayor of St. Thomas, Ontario, received an announcement from Oglivie Flour Mills that a gift of $100 would be made to the organization in that area which, in the opinion of the City Council, was giving the best service to the community. It was decided unanimously that the gift should go to the Women's Aid of St. Thomas Memorial Hospital. The President of this active and enthusiastic group is Mrs. Gladys M. Taylor.

J. L. Bateman Accepts Post at Stratford, Ontario

Mr. Jack L. Bateman, for the past year administrator of the Children's Hospital, Halifax, has been appointed to the post of superintendent of the Stratford General Hospital, Stratford, Ontario.

Coming out from England in 1948, Mr. Bateman joined the staff of the Children's Hospital in May of that year. Formerly assistant secretary of the Royal Infirmary, Preston, England, he has had considerable experience in administration and is a Fellow of the Institute of Hospital Administrators (Eng.).

At Stratford, where Mr. Bateman will assume his duties at the beginning of the new year, a new 168-bed hospital will be completed shortly.

Two little girls were discussing their families. "Why does your grandmother read the Bible so much?"

"I think," said the other little girl, "that she is cramming for her finals."

Possible Source of Error in Estimating Blood Alcohol

A point in technique which may lead to doubt of the accuracy of a blood alcohol estimation was discussed by Professor G. H. W. Lucas of the Department of Pharmacology, University of Toronto, in the September issue of the *Canadian Medical Association Journal*. Physicians have been so accustomed to using ethyl alcohol for cleansing the skin that it may be used inadvertently when drawing a blood sample for an alcohol test. While it is true that the careful physician allows the alcohol to dry before inserting the needle, the use of alcohol as a cleansing agent, where the courts may be involved, leaves the degree of dryness a subject for argument.

Where alcohol is employed to sterilize the needle, or perhaps the syringe, the potentialities are much more serious. One drop of alcohol in the 10 c.c. taken is sufficient to produce a level of about 150 mgm. per 100 c.c. of blood, a level accepted in some parts of Europe and in some parts of the United States as that producing alcoholic intoxication with respect to driving a motor car. Already a number of guilty persons have escaped justice by virtue of this technical point.

Professor Lucas recommends the use of the newer cationic detergents, such as benzalkonium chloride (zephiran chloride) U. S. P. or a non-official preparation, centrimide (C.A. T.B.). These are powerful germicides in aqueous solutions. For surgical instruments zephiran chloride 1:1,000, or centrimide 1:100 is sufficient. These reagents may be employed on the skin, and for emergency purposes, where boiling a syringe and a needle is impossible, it will sterilize them adequately. The Department of Pharmacology has established that neither of these antiseptics affects the reagent employed in the test or changes the amount of recoverable alcohol after contact overnight with the blood sample.

U.S. Hospital Insurance Roll Increased to 60,995,000

About 60,995,000 persons in the United States were enrolled in some form of voluntary insurance providing hospital care as of the end of 1948, according to a report issued by the Health Insurance Council in New York. This represented an increase of more than 8,000,000 over the 1947 figure. During 1948, the number of those with insurance covering surgical expense rose from 26,247,000 to 34,060,000. The number insured against general medical expenses increased from 8,898,000 to 12,895,000.

High Luster Shortens Service

Vanity prompts everyone to buy shiny instruments, yet the buffing which is necessary to develop the high luster often removes most of the protective coat, particularly on sharp edges and bends. "Satin finish" plating is the most serviceable, particularly when chromium is deposited over a coating of nickel. It represents the surface as deposited electrolytically; it is usually uniform in thickness but is dull and lusterless. Perhaps half of this coating is removed by buffing to give luster and with it years of service are sacrificed. — *"The Aseptic Treatment of Wounds", by Carl W. Walter, M.D.*

Miles G. Brown, M.D., M.C., C.D

Dr. Miles G. Brown, former superintendent of the Hamilton General Hospital, Hamilton, Ont., died on September 5th following a prolonged illness.

Born at St. Stephens, N.B., he was graduated from Queen's University in 1916. Enlisting that year with the 85th Infantry Battalion, he was awarded the military cross for distinguished service overseas.

Dr. Brown joined the staff of the Hamilton General Hospital as an intern in 1919, serving as assistant medical superintendent and then medical superintendent until his retirement in 1947. Among his contributions to the hospital, the greatest was perhaps in planning the Mount Hamilton Maternity wing, one of the finest hospitals of its type in Canada.

An active participant in the field of hospital organization and administration, he was for some years a member of the board of directors of the Ontario Hospital Association and in 1944 became a member of the American College of Hospital Administrators. Dr. Brown also played a large part in building up the very fine library at the Hamilton Academy of Medicine.

Charles K. P. Henry, M.D., F.R.C.S.(C), F.A.C.S.

Dr. Charles Henry, prominent Canadian surgeon, died on September 15th at the age of 72 years. Before his retirement in 1947, he had been for many years chief surgeon at the Montreal General Hospital. There, in 1916, he performed the first blood transfusion recorded in Montreal and he also organized the first radium clinic at that hospital.

On the surgical teaching staff of McGill University for more than 40 years, Dr. Henry was professor of surgery and chairman of the department of surgery when he retired. He was also director of the thyroid clinic. He was a Fellow of the Royal College of Surgeons (Canada), a Fellow of The American College of Surgeons, and a past president of the Canadian Association of Clinical Surgery.

Brick Walls Are Not Enough

A hospital is not just four brick walls, modern x-rays, laboratories, and other scientific equipment with their highly technical personnel; but a hospital, truly functioning, is a living institution. Its real value, assuming proper equipment, is in the efficiency with which it is run; in the quality of its professional staff and the organization of that staff into an effective, co-operative teaching and working unit; in consultations, freely asked for and given; in permitting to practise only those whose training and experience justify the confidence of the hospital and the community; in encouraging each to work according to his own experiences and training; and in the contribution of each who dies to the character and to the ever-increasing knowledge of all to whom the care of the sick is entrusted.—*Leland S. McKittrick in "The Hospital in Contemporary Life".*

Some books are to be tasted, others are to be swallowed, and some few to be chewed and digested.—*Francis Bacon.*

Your Pharmacist

(Concluded from page 68)

Macalaster-Bicknell ampoule filler is used to fill these, speeding up the procedure greatly.

For the stores department we manufacture such items as red and blue writing ink, furniture polish, a deoderant of the "air-wick" type, glue for pad backing (medical forms, and letterheads are printed within the institution) and window spray cleaner.

The staff consists of two qualified pharmacists and a registered nurse. In moving to the new building, the department will occupy about 4000 square feet of space, so laid out that the director of pharmacy will easily be able to maintain supervision over all activities. Dumb waiters (electric), two-way radio communication, and a pneumatic tube system will be installed to facilitate service. New equipment, for which there is no space at present, will include tubing apparatus for manufacturing lubricating jelly, electrode paste, et cetera, and steel steam-jacketed mixing tanks for preparing solutions such as cresol with soap. Schwartz sectional cabinets will take care of regular stock, while open steel shelving will be used for bulk storage. The new plans have been studied carefully with a view to ensuring adequate and speedy service within the department and inter-departmentally. Since the pharmacy is the most extensively-used therapeutic facility of the modern hospital, it follows that, if it is properly organized and operated, the patient will be ensured safe and adequate pharmaceutical service, waste and deterioration due to faulty storage will be eliminated, there will be adequate control of medicinals, and manufacturing will be carried out to the extent of saving many thousands of dollars annually.

Centralizing sterilization under the direction of the pharmacists provides a method of standardizing surgical dressings and equipment; it affords greater economy since more effective control is exercised; fewer staff and less equipment are required since procedures are not carried out on individual floors; and, finally, an added convenience is afforded to the hospital. It is by having sufficiently qualified supervision in this type of service that the patient is ensured safer and more adequate care.

Frederick Smith, M.B., B.Ch., M.R.C.P., F.R.S.C.

Dr. Frederick Smith, dean of the faculty of medicine at McGill University, died suddenly on September 7th at the age of 46. He collapsed on the lecture platform while delivering the first address of the college term to the freshman class in medicine.

A native of England and a graduate of Cambridge University, Dr. Smith came to McGill in 1931, serving the university as lecturer, professor, assistant dean, and finally dean of medicine.

Governments and Health Measures

It is time we gave them (the politicians) their just dues and realized fully that they are attempting to meet public demands. We are much too prone to belittle the efforts of our political leaders. They play in a hot league. If they accurately assess public opinion often enough, we hail them as leaders and statesmen. If they fail to do this, we soon ignore and forget them which, to them, is punishment indeed. Moreover, more and more of our leaders are looking upon governmental and social problems as a science and are trying sincerely to inform themselves of the laws governing this science.

We know, or ought to know, that there is a gap between the technology of modern medicine and its social application, for the simple reason that many of our people cannot pay for many of the costly services now used in the treatment of many diseases and injuries. We know also that the public, in attempting to put its own house in better order, has every right to apply the principle of health insurance to its medical costs if it chooses to do so. The average citizen has gone a long way in the past twenty years in his understanding of health insurance. Also, he is learning very rapidly that he can have nearly anything he wants through the ballot box.

—W. V. Johnston, M.D.,
President, O.M.A.

Nursing Situation

(Concluded from page 33)

time something more was done about it. There would be no intention whatsoever, in starting this new school, to interfere with the present established set-up in Alberta. Let the present eleven training schools go on producing nurses to the maximum extent of their ability. The central school would be something over and above the present program. This central school could be patterned somewhat along the line of the demonstration school above mentioned but not follow it exactly. My idea would be to have all the science instruction given during the first year and then have the students go out and receive their bedside instruction in the small fifty-bed hospitals.

This arrangement would call for fewer science instructors whose services are difficult to obtain. The fifty-bed hospitals would have to be selected in accordance with the quality of work being done there. Travelling instructors in nursing arts would have to visit the smaller hospital routinely, and see that the bedside instruction was being properly carried out. I would suggest that a school of fifty students be started in the first place. I should think that a staff of one science instructor, one assistant, and one travelling instructor in nursing arts, would be sufficient for a beginning. This school would require provincial government subsidization and should be run under the auspices of the university. Students would also pay fees. It has been suggested that the smaller hospitals, which are presently short of nurses, might be prepared to pay the fees of girls from their districts with the understanding that nurses return to those districts for two years after graduation. If this plan were initiated, approximately fifty more nurses would soon be available annually in the Province of Alberta and the present situation corrected to that extent. Also, immediately the school was instituted, there would be more hands available to do the many tasks required in the fifty-bed hospitals, although this would not be the main objective of the plan. In order to make this course available to more students, it has been suggested that the entrance requirements be lowered to junior matriculation. This point is, and I suppose always will remain, controversial. The nursing profession as a group, I believe, are against it. I do not think that the dispute over this point need necessarily hold up the plan. I would start the school using the same minimum requirements as are in existence for the eleven training schools now operating. If the applicants were insufficient in number the matter could be reviewed later.

There are many who doubt that this plan is feasible but, if we adopt a defeatist attitude and do nothing, we are certain to be no better off a year from now than we are today. It is equally certain that the plan to produce 40,000 additional hospital beds in Canada will provide no additional benefits to the people unless 17,000 additional nurses are produced to nurse the sick in them.

Training in Internal Medicine

The best training is found in a clinic where the highest type of medical practice is exhibited and where there is a group actively engaged in clinical research. The staff of such a clinic should be comprised of individuals of varied interests and capabilities. Of prime importance is a group of full-time men, the chiefs and assistants, of varying ages, relatively small, but who set the pace and standards for the department. Their entire time should be taken up in the care of the sick, teaching, and research, but without the responsibilities and interruptions of private practice. Within this group should be included the occasional investigator who desires and has the ability to make clinical science a career. Such a person must be assured of security and freedom; must be free of routine; must be able to take care of the sick people necessary for his studies and his teaching abilities used wisely. Close association with the preclinical departments is of great importance either through co-operation on individual problems or by assignments of staff members from one department to the other. The full-time group should constitute a functioning unit in which are included interns, residents, and fellows who are in different phases of their training. Participating with the full-time members it is essential to have a large group of men of all ages, engaged in the practice of internal medicine, who should take an active part in the teaching and care of patients in the clinic. Through this group, both students and staff benefit by having the wisdom and experience derived from private practice brought to the clinic. The men in practice have the opportunity to follow, at first hand, the advances in medicine and often make valuable suggestions as to the direction in which special technics are to be applied. An organization of this type permits of considerable flexibility. It provides an opportunity for all to make contributions, whether their interests are directed towards practice or academic careers.—*Walter W. Palmer, M.D., Presidential Address, American College of Physicians.*

Pathologists Form National Organization

The first national organization of pathologists, with tentative headquarters in Saskatoon and Toronto, was formed at the annual meeting of the Canadian Medical Association. Officers chosen included two vice-presidents, Dr. D. F. Moore of Saskatoon and Dr. John Hamilton, Kingston, Ont. A president has not as yet been named. Appointed to the executive were Dr. Harold Taylor, Vancouver, Dr. John Duffin, Calgary, Dr. D. R. McLatchie, Regina, and Dr. S. Lederman, Winnipeg.

An Old Sleeping Bag

A bag to smell unto for melancholy or to cause one to sleep. Take drie rose leaves, keep them close in a glass which will keep them sweet, then take powder of mints, powder of cloves and put the same to the rose leaves, and then put all together in a bag, and take that to bed with you, and it will cause you to sleep, and it is good to smell unto at other times. —*A New Herbal. (1578)*

Substandard Medical Care

People everywhere throughout the world suffer from two preventable causes of inefficient medical care to an extent far beyond public recognition. The causes are practice of medicine by people not properly qualified with a medical education and the advertisement and sale of secret remedies and appliances. Among the great nations of the world, many have developed legislation which should be adequate to control these menaces to the public health but by far the majority of the nations do not have adequate legislation. Furthermore, even when the law ostensibly protects the people, the funds appropriated for making the laws effective through detection of violators and suitable punishment are so pitifully inadequate as to make enforcement difficult if not impossible. One of the great services rendered by the Council of the World Medical Association has been the assembling of the facts concerning these evils in some 24 countries in which national medical organizations co-operated in supplying information and the circulation of these facts to all member nations. The reports on these subjects appear in this issue of the *World Medical Association Bulletin (July, 1949)*. The complete data concerning the individual nations are available in the office of the Secretary General of the World Medical Association and may be had on application to that office. Address Dr. Louis H. Bauer, World Medical Association, 2 East 103rd Street, New York City, New York.—*World Medical Association Bulletin (July, 1949)*.

* * * *

Soin Médical Inadéquat

Partout dans le monde les gens souffrent en conséquence de soins médicaux incapables qui dépassent bien la recognition publique. La raison pour cet état des choses—préventables bien entendu—se trouvent en premier lieu dans le fait que les soins médicaux sont administrés par individus n'ayant pas eu une propre éducation médicale, ensuite par l'abondance des annonces et la vente des médicaments et des appareils secrets. Parmi les grandes nations du monde plusieurs ont introduit législation afin de prévenir

et de contrôler ce danger menaçant à la santé publique, cependant, la grande majorité des nations ne dispose pas d'une législation satisfaisante. De plus, si les lois contenaient même une protection comme il faut, les fonds appropriés pour les rendre efficaces par détection des violateurs et des châtiments correspondants, sont pitoyablement insuffisantes, de sorte que leur exécution est extrèmement difficile, sinon impossible. L'un des grands services rendus par le Conseil de l'Association Médicale du Monde a été l'accumulation des faits concernant ces maux en 24 pays à peu près où organisations médicales nationales ont coopéré dans l'acquisition des informations et en faisant circuler les faits y relatifs parmi toutes les nations membres. Les rapports sur ce sujet paraissent dans la publication récente du *Bulletin de l'Association Médicale du Monde* (juillet, 1949). Données complètes concernant les nations individuelles peuvent être obtenues dans l'office du Secrétaire Général de l'Association sur demande addresse à cet office. Addresse: Dr. Louis H. Bauer, Association Médicale du Monde, 2 East 103rd Street, New York City, N.Y.—*Bulletin de l'Association Médicale du Monde (juillet, 1949).*

Active Board Members Give Home to Hospital

The 17-room home of Mr. and Mrs. J. H. C. Waite, Brampton, Ont., has been offered as a gift to Peel Memorial Hospital. Mr. Waite is a past-president of the hospital's board of governors and chairman of the building committee, which has been responsible in no small way for the new 28-bed addition now under construction at the hospital. Vice-president of the Women's Hospital Aids Association of Ontario for 10 years, Mrs. Waite has served as vice-president and member of the board of governors of the hospital.

The four-acre property, valued at $100,000, contains a large swimming pool and rock and flower gardens. In making the gift, Mr. Waite informed the board that they could either use the property as a nurses' residence or sell it, employing the proceeds for other hospital purposes.

Provincial Notes

(Concluded from page 64)

Sarnia General Hospital Board of Commission in presenting a $1,000,000 hospital by-law to the rate payers. The present hospital is outmoded and must be completely renovated and remodelled.

Quebec

MONTREAL. A new staff residence has been opened at the Jewish Hospital of Hope. This is the first part of an extension plan, which is expected to cost $1,000,000. The second will consist of extensions and alterations to the present hospital building, and the third and last will be the addition of two new wings to the hospital.

With the Hospitals in Britain

(Concluded from page 58)

of war was quite remarkable but, as the subject has been discussed earlier this year (May, p. 56), there is no need for me to go into it again at length.

The importance of this report in its bearing upon all matters relating to family life cannot be over-stated, as it is impressed throughout with knowledge, precise information, and understanding.

Book Reviews

(Concluded from page 52)

Britain. It is interesting to note his comment that "American hospital administrators now admit the fundamental defects of the vertical type of hospital". (We had not gained this impression except for small hospitals.) However, the author reviews evidence favouring the vertical plan. Some features of the layouts discussed would not be applicable here, such as the provision of a porter's lodge, but these are merely detail. More attention is paid to verandah space than is the practice here. Panel heating would seem to be favoured, as are also top floor kitchens. The author would provide separate dining rooms for interns, for sisters, or senior post nurses, for staff and student nurses, for the female domestic staff, and for those normally non-resident such as the clerical staff, male nursing staff and the male domestic staff.

The book contains a tremendous amount of information. Some subjects are handled rather sketchily but this can hardly be avoided in a single-volume work. The illustrations are clear and to the point, although the line drawings would have been improved if the captions and explanatory notes had been set in ordinary type rather than in the usual hard-to-read hand-drawn lettering used by draughtsmen.

Chest X-rays of Office Patients

In order that the Gage Institute Chest Clinic, Toronto, may be of further service to physicians in the detection and prevention of tuberculosis, a permanent miniature chest x-ray unit has been established at the Clinic, to which office patients may be referred by appointment. This new service will be given free.

Private patients referred for miniature chest x-ray only will not be recalled by the Gage Institute Chest Clinic automatically even if further examination is desirable. Arrangements for follow-up examinations will be left to the patient's physician.

Windsor Probe

(Concluded from page 46)

reorganization of the Board. He would leave the Mayor and the County Warden off the Board, partly because they are both too busy with other matters, and partly because they are the focal points of politics in their respective municipalities and anything they say or do assumes a political texture. Nor does he favour representation on the Board of industry, labour or other interests. The Board needs more business experience in its personnel. It also needs someone with professional engineering experience and one with a legal mind. The representatives of the City should be carefully reviewed. A Board of eleven is to be appointed:

Three by City Council
One by the Chamber of Commerce
One by the Hospital Aid
One by the Medical Staff
One by the County
Four by a Hospital Trust Association.

The latter body has been recommended to permit the citizens to take an active interest in the support and welfare of the hospital and to become active partners with the municipality in furthering its development.

Except for the medical appointment, a statutory arrangement, the basis of appointment should be a two-year term.

Since the publication of this report the Board of the Metropolitan Hospital has appointed Mr. Robert Buckner, formerly administrator of Niagara Falls General Hospital, as the new superintendent.

Public Education

(Concluded from page 31)

laws and that these tests are in his interest.

With reliable information about hospital procedures made available, the general public will have an opportunity to learn that hundreds and thousands of dollars worth of equipment, and hundreds of skilled technicians and nurses are at their disposal whenever they enter hospital, and that these facilities are not arrayed against them but marshalled behind them.

A Gift of the Gods

A wide-awake community requires of its hospital or hospitals at least three things: efficient medical service, economy in construction and administration, and a reasonable measure of comfort and convenience for patients and their friends. Efficient medical service in a hospital depends upon the talent and character of the medical staff, and staff organization. Adequate technical equipment is, of course, indispensable, but it is assumed that this will be furnished in any case. As to native capacity and personal character, a hospital must take what the gods grant. Men of exceptional talent and extraordinary moral worth may be shifted about from hospital to hospital, but they cannot be conjured into existence out of an empty void. The actual problem of the hospital administrator is to make the best possible use of such talent as may be available.—*S. S. Goldwater, M.D.*

Men occasionally stumble over the truth but most of them pick themselves up and hurry off as if nothing had happened.—*Winston Churchill*

Liverpool School of Tropical Medicine— Fifty Years of Service

One of the first schools of tropical medicine, the Liverpool School of Tropical Medicine, celebrates this year some fifty years of service. Towards the end of the last century, the importance of providing instruction in tropical medicine to the medical officers of the Colonial Medical Service became more and more apparent. Mr. Joseph Chamberlain, then Britain's Secretary of State for Colonial Affairs, recognized this fact and tried to interest medical schools in specialist courses of tropical medicine. As an indirect result, a Liverpool shipowner, Sir Alfred Jones, founded the Liverpool School of Tropical Medicine in 1899.

In that year the first research expedition organized by the School was dispatched to Sierra Leone, West Africa, the first of 32 similar expeditions to West and Central Africa, Brazil, and the West Indies. The material collected during these expeditions was brought back to the laboratories of the School for scientific investigation. In 1921 the "Sir Alfred Jones" Laboratory was founded in Freetown, Sierra Leone and, for the next two decades, work of fundamental importance was carried out. When in 1941 the illness of the director forced the closure of the Laboratory, the Liverpool School, in its stead, made its headquarters in Freetown.

During these years vast inroads were made into the causes and control of many tropical diseases: various methods of mosquito control were developed; the causes of sleeping sickness were identified; the study of yellow fever was concentrated in Brazil; quinine and, later, paludrine were introduced in the fight against malaria.

Today every merchant seaman serving in ships visiting West Africa and other tropical ports knows the centre belonging to the Liverpool School of Tropical Medicine where he may obtain treatment with the latest antimalarials at any time. Plans for the enlargement of the Liverpool School buildings will, in the near future, enable the School to expand its field of activity still further. — *Courtesy, United Kingdom Information Office, Ottawa.*

Keep Them Happy

Today enlightened management recognizes the inescapable truth that it and the employees are in the same business and share equally in its success or failure. Management realizes that it must treat employees as individual personalities; that an organization which endeavours to cooperate with its personnel to the end that each person may develop and utilize to the best advantage his talents and capabilities, . . . is building for the future; that an organized, planned approach to the employer-employee situation is absolutely essential if management wishes to (a) increase the efficiency of the working force and at the same time reduce operating costs, (b) increase the satisfaction and morale of all employees, and (c) protect the physical and mental well-being of employees.

—*Carl I. Flath.*

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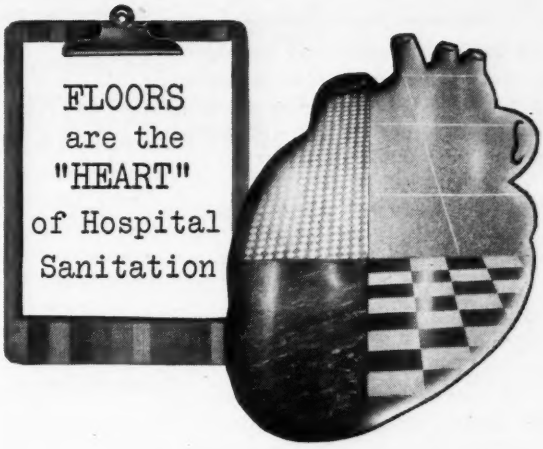

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Ancillary Services

(Concluded from page 40)

prise between hospitals and community social agencies. The hospitals must undertake responsibility for initiating the rehabilitation program and the community must carry it to a successful conclusion. This co-operative approach seems to be gaining favour in most communities. The practical point of this arrangement is to know at what stage of rehabilitation the responsibility of the hospital ends and that of the community begins. This will, in every case, be a matter of individual hospital policy. The hospital's responsibility in the rehabilitation program must be recognized, and the workers, professional and volunteer, needed to discharge its obligations must be considered as members of its staff. Whether or not rehabilitation workers should be counted in the staff-to-patient ratio or included in the costs per patient per day or the cost per out-patient visit is a question which allows for considerable difference of opinion. Some hospital authorities feel that rehabilitation is a socio-economic service that is applicable only to certain communities, to certain types of hospitals, and to certain types of patients, and therefore is not a legitimate charge against the treatment of patients. Nevertheless, we must also recognize that successful rehabilitation depends upon a good start which cannot be assured unless the initial stages are integrated with the hospital services and co-ordinated with other departments by the hospital director. In its early stages, rehabilitation is indistinguishable from treatment.

That the service is a benefit to the community is undeniable and the question of which agency should be charged with the cost is important only from an accounting point of view. After all, a hospital is only an agency of service to the community and whether the money is spent by the hospital or by other community service agencies is of little import so long as the community stands to benefit from the disbursement. In the long run it is more economical for the community to spend its resources on hospital care and rehabilitation, which are limited as to time, than on disability benefits which last indefinitely.

The Patient and His Friends

(Concluded from page 72)

problem of observing regulations will be minimized.

Public Education

Moving pictures are being used to educate parents in child guidance, and to explain various civic needs. Why not a short film then which would illustrate the care of the patient, his need for rest, the right approach and conversation? That is a dream for the future. Meanwhile, by public addresses, the press, and posters, people could be interested in our problem and asked to assist. They could be persuaded to adhere to hospital regulations that would be recognized, not as arbitrary rules laid down for our convenience, but as a time set aside for public participation in a hospital routine that is designed for the welfare of the patient.

A request for help strikes a responsive note in every one of us. We must be needed. If the friend or relative is assured that we recognize his need to the patient and, therefore, his need to us in caring for the patient, he will be satisfied. A satisfied individual is a co-operative one, and co-operation of friends and relatives is soon reflected in the attitude of the patient.

Thus, by brief but adequate information, by improved physical facilities, by sharing with the friends and relatives our efforts to reach our common goal, the patient may be better served.

"We cannot do otherwise than view the social scene from whereever we may happen to sit," but we as administrators are able to change the place where the patient's friends or relative sits, and so alter his view of the scene and the part he plays.

Ernest Lee Appointed Director of Physical Fitness

Ernest Lee, director of physical education and recreation for the province of British Columbia since 1946, has been appointed National Director of Physical Fitness in the Department of National Health and Welfare and chairman of the National Council of Physical Fitness. Mr. Lee has been British Columbia's representative on the National Council of Physical Fitness for the last three years. He has also played a leading role on the social planning committee of the Vancouver Welfare Council.
